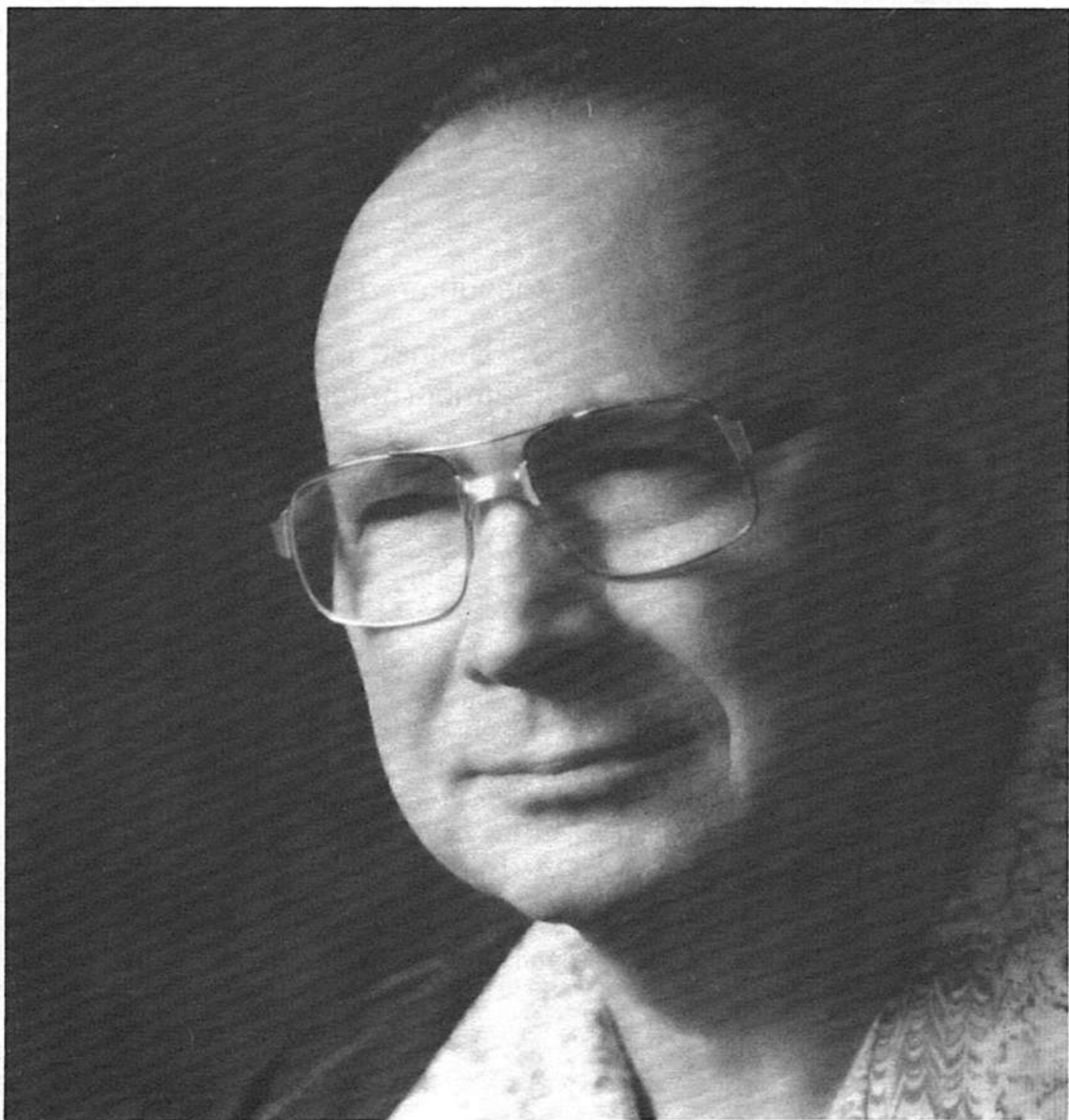


COUNCIL ON DIAGNOSIS AND INTERNAL DISORDERS
OF THE AMERICAN CHIROPRACTIC ASSOCIATION

THE CHIROPRACTIC FAMILY PHYSICIAN

NOVEMBER 1979

VOL. 2, NO. 1



CASMER NEDZWECK, D.C., F.I.C.C.

"DYNAMICS of CORRECTION of ABNORMAL FUNCTION" TERRENCE J. BENNETT LECTURES



Dr. T.J. Bennett

EDITED AND PUBLISHED

By

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the Chiropractic FAMILY PHYSICIAN

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THE CHIROPRACTIC FAMILY PHYSICIAN is published bi-monthly by the Council on Diagnosis and Internal Disorders of the American Chiropractic Association, P.O. Box 1577, Glendale, CA 91206.

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Circulation: Not less than 11,500.

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SALUTE TO CASMER NEDZWECK, D.C., F.I.C.C.

William A. Nelson, D.C.

In June, 1970 this council, struggling to become organized, received an application from Casmer Nedzweck, D.C. Long an avid student and family practitioner, Casmer recognized the need in the profession of improved diagnostic skills.

A graduate of Palmer, Casmer has practiced for many years in Detroit with his wife, Dr. Helen Nedzweck. Always eager to advance his knowledge, Casmer has attended most of the varied professional courses offered in the field. Consequently, it was to be expected that he would qualify as an internist in Michigan.

At his own expense he attended an organizational meeting of the Council on Diagnosis and Internal Disorders in Las Vegas, Nevada. Here his interest and ability were quickly recognized and Dr. Nedzweck was promptly elected secretary. Reelected year after year he has expertly filled a most important position on our board of directors.

Four years ago we had an opening in the office of vice president for which we did not have a suitable candidate. Casmer stepped into the breach, was elected, and again we had an efficient crew. Vice president was followed by the office of president and we now salute him as our immediate past president. It should be mentioned that during his tenure as president he became a Fellow in the International College of Chiropractors, Inc. and he also achieved the status of diplomate internist.

Although still on the board of directors, he will now have more time to enjoy suburbia and the pleasures of power boating on Lake St. Clair. We salute Dr. Casmer Nedzweck for his dedication, zeal and forthrightness in the workings of this council and we appreciate the hours and dollars he has contributed to the advancement of this council and his profession. □

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PRESIDENT'S PAGE COUNCIL ON DIAGNOSIS AND INTERNAL DISORDERS

Eldred A. Wilson, D.C., Council President

It is with a great deal of enthusiasm that I greet the nearly 100 new members to our council in the short period of 6 months, among whom are several well-known physicians. Your Board of Directors are grateful for this acceptance of the Council on Diagnosis and Internal Disorders and that for which it stands.

More questions regarding diagnosis and treatment are being directed to this council. More Chiropractic College students are applying for membership in this rapidly growing, dynamic council. More specialists from other areas are also applying for membership.

It is becoming more and more obvious that the days when the chiropractor adjusted the patient and the patient got well, but neither doctor or patient knew why, will soon be a thing of the past. This is being replaced by the knowledgeable physician who makes an examination, correlates his findings, makes a diagnosis and then adjusts his patient. The doctor knows what he is treating and the patient is aware of the physical condition and knows that chiropractic solved his problem.

I would like to suggest that you re-read and study the material presented by Dr. Ralph Martin in the September issue of the Family Physician regarding breast masses, their detection and treatment. This was a very informative and useful clinical paper and certainly bears reviewing. It gives us a method of examination and treatment that we can apply immediately. It is also indicative of the type of material we will try to keep available in each issue of the Family Physician.

We promised you research this year and it is, at this moment, getting ready to start. More information will be available in the next issue of the Chiropractic FAMILY PHYSICIAN. □

ANNOUNCEMENT

All family physicians in the Twin Cities/Des Moines areas are invited to enroll in classes to become chiropractic INTERNISTS. Starting in January, 1980 these classes will be held in nine month increments.

Jointly sponsored by Northwestern Chiropractic College and the Council on Diagnosis and Internal Disorders, the classes have been approved by CCE.

As class size will be limited, you are urged to apply at once to Dr. J.R. Wildenauer, Director of Postgraduate and Continuing Education, Northwestern College of Chiropractic, 1834 South Mississippi River Blvd., Saint Paul, MN 55116.

When making your reservation be sure to indicate which class you prefer — Twin Cities or Des Moines.

This course is structured to provide practical, usable material for the practicing physician. As your diagnostic ability is advanced, you will realize remarkable improvement in your therapy. □

EDITORIAL

by
Richard H. Tyler, D.C.

Not long ago I had the fortune or maybe it was the *misfortune* of seeing a national TV show that had as one of its segments a report on chiropractic. The program is one of the top rated in the country and for months there had been a campaign by some in our profession to have them do a story on chiropractic. They seemed to feel that the exposure was needed. I cringed at the thought. While the vast majority of those in the profession are worthwhile physicians there is that small group of dedicated and quite vociferous bimbos who are an embarrassment to us all.

As just about everyone knows, the program aired not once but twice. Generally we came off well enough not to have to hang our collective heads in shame. While I could find a number of things I would have liked to have changed there was one section which I thought was depressing because of the incredible nonsense spouted by two of those interviewed. In the past I've vented my disgust on the holy straights for their ridiculous adherence to a single cause concept. Now we have our own Laurel and Hardy act by two chiropractors calling the rest of us "quacks" if we think that chiropractic adjustments can do anything else but relieve back pains. The one who did most of the talking seemed to base his hypothesis on the fact that he tried to cure someone of multiple sclerosis once — he tried for a whole year and it didn't work — therefore anyone else who says he can affect function by adjusting structures — no matter what technique — is a "quack". The bitter babbling of the two was a little scary. I think they really believed the dribble they were spouting.

In chiropractic we have the most powerful single weapon in the arsenal of conservative therapeutics. Even the most rabid allopathic physician will either directly or otherwise admit that an aberrant structural condition can cause the manifestation of a functional pathological process. An example of this can be found in the medical text "Orthopedic Disease" by Aegerter and Kirkpatrick. In the section of Padgett's Disease they allude to the resulting exostoses in the cranial area causing a mechanical pressure on the nerves passing through various foramina and therefore adversely affecting vision and hearing. Get it? Excessive mechanical pressure upon neural structures causing functional distress in the innervated tissues. Through extrapolation does it not make sense that the removal of the excessive pressure causing the pathology would restore functional integrity? Does it not make sense that the removal *anywhere* of a stress provoking situation through the maintenance of structural integrity would beneficially affect the tissues that had been adversely affected? I'm a voracious reader and I can tell you from experience that medical literature is almost bogged down with *researched* evidence that what we do is right. I'm fed up with the apologists kissing the medical backside so that they will like us. "We know our place. Just let us work on sore backs," is their philosophy. B--- you bet I can help that person with a heart condition — that person with a kidney problem — that person with a hearing problem. We can help anyone who has as a cause of his problem stress due to a structural aberrance. We can also synergistically benefit that same patient with the proper use of physical therapy, reflexology and nutritional counseling. In other words I can create within the body a situation in which it can effect its own cure.

Continued on page 7

CHIROPRACTIC COLLEGES RECEIVE 1979 GRANT AWARDS FROM THE ANABOLIC FOUNDATION

Dr. Gordon Holman, Chairman of the Grants-Awards Committee of the Anabolic Foundation, has announced the names of nine (9) chiropractic colleges who have qualified for financial grants under the Anabolic Foundation.

The Grants-Awards Committee, consisting of Dr. Cynthia Preiss, of Glendale, California, Mr. William Luckey, editor of Chiropractic Economics, and Dr. Gordon Holman, Chairman of the National Board of Examiners, met at the home of Dr. Cynthia Preiss to review applications submitted by various colleges for grants.

At the conclusion of this meeting, the following colleges were named as recipients of grants:

- Canadian Memorial Chiropractic College
- Cleveland Chiropractic College
- Logan Chiropractic College
- Los Angeles College of Chiropractic
- National Chiropractic College
- Northwestern Chiropractic College
- New York Chiropractic College
- Texas Chiropractic College
- Western States Chiropractic College

In making the awards, Dr. Holman stated that grants were issued for the express purpose of providing laboratory, clinical, or teaching aids. Dr. Holman explained that this best accomplished the main goal of the Anabolic Foundation, which is to provide tangible and positive benefits to the many students in chiropractic colleges, rather than a select few.

The profession is indebted to the Anabolic Foods Company and its many representatives throughout the United States and Canada for this assistance program. □

Continued from page 6

I'm a chiropractic physician. I can unleash in the body the most potent curative forces in the healing arts through the use of conservative therapeutics. I won't let a couple of dingbats take that away from me. Remember chiropractic is the fastest growing of all the healing arts because — it *works*. In spite of the weirdos we seem to have — it still works. I feel this is so not because we work *on* the body but because we work *with* it. So — regardless of our divergent philosophy let us always remember the tie that binds us can never be destroyed because it's the physical application of *truth*. □

CLINICAL ROUNDTABLE

Eugene J. Kraemer, M.T., D.C.

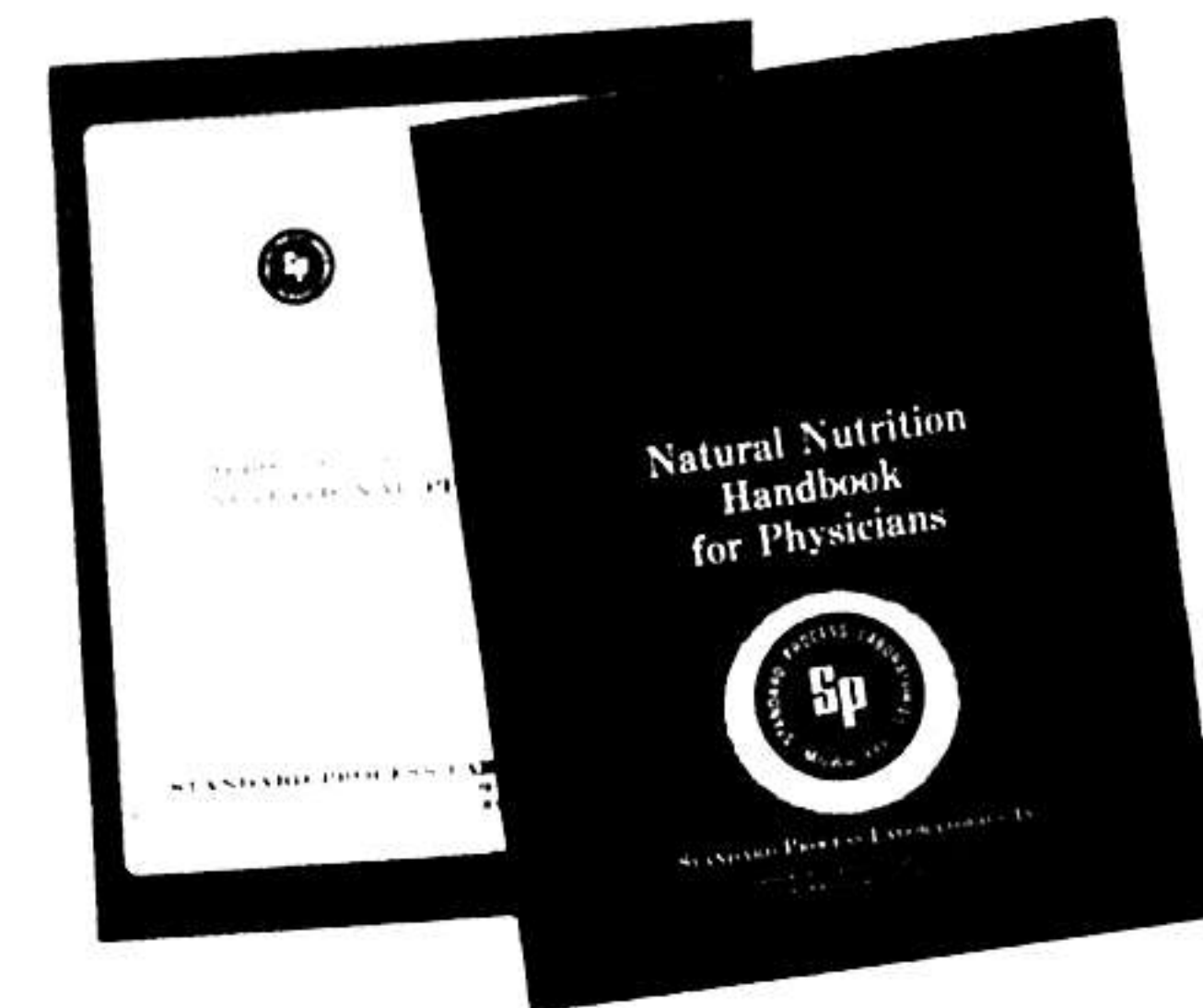
HDL CHOLESTEROL: A significant lipoprotein risk factor for coronary artery disease

1. HDL refers to High Density Lipoprotein which can be separated from serum or plasma by ultracentrifugation or by chemical precipitation; and then assayed by measuring its cholesterol content. HDL cholesterol represents one fraction of the total serum cholesterol. The other lipoproteins include LDL (Low Density Lipoproteins), ILDL (Intermediate Low Density Lipoproteins) and VLDL (Very Low Density Lipoproteins) each containing cholesterol as a constituent making up the remaining fractions of total cholesterol. It should be noted that most of total cholesterol reside in the LDL cholesterol fractions. Serum or plasma lipids, Lipoprotein Electrophoresis, Lipophenotyping and Lipoprotein Cholesterol Fractions correlate as follows with approximate upper limit of normal values *after fasting 12 to 16 hours*.
 - a. HDL = alpha-1 lipoprotein; as cholesterol = 60 mg/dl
LDL = beta lipoproteins; as cholesterol = 200 mg/dl
VLDL = prebeta (alpha-2) lipoprotein; as cholesterol = 40 mg/dl
ILDL = broad or dysbetalipoproteinemia = 0
Chylomicrons = 0
Cholesterol Total = 300 mg/dl
 - b. Hyperlipoprotein Typing:
Type I = increased chylomicrons (dietary triglycerides ↑)
Type IIa = increased LDL (cholesterol ↑)
Type IIb = increased LDL and VLDL (cholesterol ↑ and metabolic triglycerides ↑)
Type III = increased ILDL (cholesterol ↑ and metabolic triglycerides ↑)
Type IV = increased VLDL (triglycerides ↑ and cholesterol variable ↑)
Type V = increased chylomicrons and VLDL (dietary and metabolic triglycerides ↑ and cholesterol variable ↑)
 - c. Other laboratory correlations:
Lipemia, serum = turbidity = elevated VLDL and/or chylomicrons: after 16 hours of refrigeration (4°C), chylomicrons = creamy (floating) layer; VLDL = subnatant turbidity
Triglycerides = mostly VLDL and chylomicrons
Cholesterol = mostly LDL
2. The purpose of this statement is to elaborate on the meaning of lipid and/or lipoprotein values as they relate to the risk of coronary artery disease manifested by myocardial ischemia. There are numerous variations in the distribution of lipids and lipoprotein in plasma or serum leading to numerous classifications and clinical syndromes, both hereditary and acquired. However, it seems at this time that the most significant information attempting to assess risk of coronary artery disease is the recently documented fact that the level of HDL cholesterol is inversely related to risk. HDL seems to prevent coronary atherosclerosis and so high levels are protective; LDL and total cholesterol levels are directly related to risk and seem to be a causative factor in the development of coronary atherosclerosis.

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CLINICAL USE OF GLANDULAR PRODUCTS

by
Peter Martin, D.C.

Glandular tissue products have long been in use by the Chiropractic profession. While the extent of usage has waxed and waned over the years there has always remained a faithful coterie of doctors utilizing the glandulars even though the only basis for their use has been empirical.

A number of theories exist to provide a rationale for the use of glandulars. Many doctors believe there is a direct hormonal effect, yet quantitative analysis would prove that the amount of hormonal activity present in a tablet of raw gland concentrate is really quite negligible.

Another theory is that the ingested tissue substance acts as a sort of 'red herring' protecting the tissues of the body by attracting invasive forces to itself.

A more rational theory is that propounded by Dr. Alan Nittler in a recent issue of the Journal of the International Academy of Nutritional Consultants. In this article, here reproduced, Dr. Nittler provides evidence that specific amino acid combinations found in glandular tissue tend to aggregate in the like organ or organs in test animals ingesting the tissue preparations. □

THE THERAPEUTIC USE OF TISSUE AND GLANDULAR SUBSTANCES

It has long been a debate in the profession as to whether glandular and tissue extracts are valuable as therapeutic agents. Among the physicians who use them clinically, there is no doubt that they have value, sometimes quite beyond expectations. They have empirically observed the evidence in patient response time and again. This is, at least in part, the use of the scientific approach to the problem: Observation leads to theory.

The rationalists, however, who have neither used the substances nor experienced their effects in clinical practice have said that it is impossible for such results to be forthcoming. To them it is true, very simply, because the tissues and glandulars are protein substances and, as such, are digested into component parts in the alimentary canal. In fact, they are broken down into amino acid units before absorption into the system and cannot be distinguished as a specific tissue or gland substance. This is a philosophical type approach, at least in part, because there has not been any observation of what happens in reality.

Now comes the day of reckoning. The philosophical have turned into the empirical by using the scientific approach of laboratory observation. Experimental work has been accomplished and published to the effect that tagged carbon atoms as found in purine, pyrimidine and nucleic acid substances have been consumed in the dietary and later isolated from the corresponding tissue of gland of the consumer. There actually is a specificity of these substances in the dietary for specific glands and tissues in the body. Here is an abstract.

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THE CHIROPRACTIC FAMILY PHYSICIAN

E.A. Wilson, D.C.

The more I can do for a patient at the office, the better control I am going to have of that patient's progress. I do not like to send a patient to the drug store even to buy a box of aspirin. I want them under my control at all times as much as possible since I am responsible for their welfare. In this respect I mix various remedies myself rather than hazard the drug store visits of my patients. I have found that a powder mixture is very effective for external application on numerous minor abrasions, scratches, etc. It can be in proportions depending on what you want to accomplish with it. The sulphur is a healing agent, the boric acid is an antiseptic and the alum is an astringent. It can also be mixed with lanolin or vaseline to put on insect bites and stings. Speaking of insect stings, we get a lot of that here in the country. Epsom salts, baking soda, vitamin C, Ultraviolet, Osmopak (an ointment that contains Epsom salts) or Numotizine which is a good ointment to use on any insect bit or sting, especially the big red ants. There are a lot of ants in these parts in the summer time and people, especially children do get these ants on them and get stung by them. Numotizine ointment applied to these bites is very effective.

I just released a young lady 17 years old who dropped out of Columbia University due to mononucleosis. The clinic doctors at the University diagnosed it as such. When she arrived in town she came to my office, but as you know, this is not necessarily a referral case. There was no need to send her to a medical doctor. The antibiotics are definitely contraindicated in mononucleosis. All they told her at the clinic was to go home and rest. That was their treatment. She, however, came to my office having been a former patient for quite some time. I did not run more laboratory tests, but accepted the diagnosis given by the doctors at the university clinic. I started adjusting her twice a week and put her on a high protein diet, 4000 mg. of vitamin C daily at intervals, a stress vitamin . . . high in B complex with added B6. This particular treatment was kept up for thirty days and at that time I ran another test for mononucleosis. It came out completely normal. The girl apparently was recovered from it, but as we know this could have flared up again at anytime, so we continued with the treatments for a while longer. I might add that the only thing done at home in addition to the vitamins was cool compresses around her neck to reduce the inflammation of the sore and swollen cervical lymphatics. These cold packs will definitely reduce this swelling to the point that the patient is fairly comfortable.

Here is another general practice case which was primarily a case of giving advice for another member of a patient's family. A mother was in my office and told me about her son. I had never treated this boy for any particular illness. She stated that every morning when he got out of bed his head was so full of mucous he could hardly breathe for an hour or more. He was coughing, hacking and blowing almost constantly. She wanted to know if there was anything he could take for the condition. Well, of course not. I questioned her about him and found that he was quite a milk drinker, so I suggested to the mother that she take him off milk and any kind of dairy products, even milk on his cereal or anything of that for about a week then let me know just how he felt. She was back for another treatment in about three days and

she said that her son had refrained from milk and was at least 75% improved. When I saw her again a week or ten days later she said he had not touched any milk and he was completely free from all mucous. He was real happy about his improvement, but then he got careless and had a glass of milk before retiring one night and the next morning his distress had returned just like it had been before. Well, this broke him and as far as I know he has not had a glass of milk since. I did, however, give the mother bone-meal tablets for him to supplement his need for calcium in the absence of milk.

In my opinion it would not have done any good if I had told his mother to bring him in and had given him a series of treatments when in reality all the adjustments in the world would not have corrected his trouble as long as he continued drinking the mucous forming milk. As far as I was concerned the milk was the 'cause', the mucous was the symptom. This is basic chiropractic principle to treat causes and not symptoms. (I found out, however, in practice that if I did not pay any attention to symptoms I would have not had a patient long enough to get at the cause of anything.) In this case, I removed the cause and the symptoms abated.

Another case that I found to be quite interesting, at least to me. I am not sure whether it should be classed as an intensive care case or not. I spent quite a lot of time with this patient and it is perhaps unfortunate that we in this profession do not have facilities to provide our patients 24 hour care in most areas of the country.

This case was a tenant farmer living in the Missouri river bottoms. The reason for relating this case is to show that even though it might be an intensive care case of an infectious illness, a chiropractic physician can handle it. He can care for it as well or better than anyone else. He came to my house one evening to see if I would go out to his place to see his daughter. He claimed that she was very ill. He was actually a migrant farm worker and had only been in the area for about a month. He tried to get one of the local M.D.s to come but was refused as it was obvious that getting paid for this call was going to be rather debatable at best. When he was refused he did not know what to do so he asked someone here in town about a doctor he could get to see his girl. Whoever talked to him referred him to me. This was about 9:00 P.M. I followed this man home. I had to follow him because down in these bottoms some of these roads are pretty wild and I would not have been able to get there. We got to his home about 9:45 P.M. I walked into the sick-room and the old characteristic odor of the flu was strong enough to almost make a diagnosis on it. For some reason there was no ventilation in the room so the first thing I did was to get some ventilation into the place. There were two windows and I at once raised them both and put a card table in front of one and a piece of plywood in front of the other so there would not be a draft across the patient's bed.

I examined the patient; she was 16 years old with blood pressure of 108/70, temperature 104 degrees, respiration rapid, shallow and some mucous rales present but not too well defined.

These symptoms had begun about 24 hours prior to my arrival. I was concerned about the heart sounds as they were ill defined and endocarditis had to be considered. Her pulse was around 100. Inasmuch as there was a considerable amount of flu in that area of the county, and both parents had bad colds prior to the girl getting sick, I assumed that it was probably the flu that they had but had not got down with it. Anyway, the girl was having difficulty in breathing and in my opinion it was more from anxiety and fear than from her illness. I talked to her and explained that her breathing

Continued on page 16

"THE DIAGNOSTIC IMPORTANCE OF A PROCTOLOGICAL EXAMINATION"

by
Richard H. Tyler, D.C.

There are few areas of greater importance and yet more often neglected than the anus and lower bowel. All too often the chiropractic physician will relegate such matters to a proctologist in the allopathic field which in most cases is a mistake. The medical proctologist will frequently use radical therapeutic procedures when, if a proper examination has been given, whatever pathological process is found can be treated conservatively.

Ostensibly we deal in pain. Very often with low back pain. It should be incumbent upon us to examine the area we are planning to treat as thoroughly as possible. This can only be done by including a proctological examination.

Most — and this means both the doctor and the patient, find a rectal examination uncomfortable. I don't believe that it can be made an enjoyable experience but if it is properly done at least it should cause only a minimum degree of distress.

Because of the discomfort that may be experienced from a rectal examination I place it at the end of the entire physical procedure. The patient must be assured at the time that you recognize the discomfort but that the examination will be done quickly and with as little annoyance as possible.

With the patient in the lateral Sims position a digital survey should be made before visualization. The examining finger of the gloved hand is well lubricated with KY jelly. With the other hand retracting the superior buttock place the examining finger at the anal sphincter. Note the tension or flaccidity of this muscular ring. There will usually be a degree of reflex tension when the sphincter is first engaged. Don't force the insertion. Wait for a moment and you should be able to feel the relaxation of the muscles. A slow insertion is then made to allow accommodation. Occasionally anal contractions will be expressed during the digital insertion. Again wait until relaxation takes place before continuing. When the insertion has been completed the examining digit should then sweep the circumference of the anal canal and lower rectum searching for such anomalous conditions as swelling, loss of muscular continuity and areas of induration or unusual masses. Don't search for internal hemorrhoids since they can usually be discerned only upon visualization.

It is during the digital examination that I feel that we as chiropractic physicians should excel. After years of palpation and consequent digital sensitization we have a diagnostic tool that few other physicians can claim. With the examining digit inserted to the maximum the cervix in the female patient and the prostate in the male may be palpated. I feel that the prostatic evaluation is extremely important since that "nagging low back problem that seems to have become chronic" might well be the initial signs of a more serious pathological process.

With the digit still completely inserted the integrity of the sacro coccyxgeal articulation may now be evaluated. This articulation is one of the most overlooked and under examined in the body. Many low back problems may be corrected through examination and implementation of proper adjustive procedures in this area.

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BOOK REVIEW

'CIVILIZED' DISEASES AND THEIR CIRCUMVENTION

by
Max Garten, N.D., D.C.
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The books reviewed in the Chiropractic Family Physician are chosen for their special merit for those who are active in clinical practice and want to keep up-to-date in all phases of modern healing practices. To say that these books have merit is not to say that we agree with everything that is stated by their authors. A book may have much merit without the reader having to agree with everything contained between its covers.

In reviewing Dr. Garten's " 'Civilized' Diseases and their Circumvention " it is admitted that the title is very intriguing and challenges one to find out what is the author's perspective that motivates the title of his book.

Dr. Garten was born and educated in Germany. He became interested in health and nutrition at an early age due to his own health crisis. He has traveled the world over searching for clues and patterns of living which might hold promise of improving the general level of human health. His book contains thirty-two chapters and a well organized and complete index in the back. The list of chapters in the Contents comprises an exhaustive list of the subjects covered in every chapter. One can conveniently and quickly find any subject or discussion desired and the scope of subjects covered is staggering and exhaustive.

Do not expect to find orthodox medical philosophy and concepts. This is a book for chiropractors who respond strongly to concepts of naturopathy and practice as chiropractic family physicians. The author makes a very strong case that 'civilized' diseases are almost entirely the result of the errors that are involved in the life-styles of western civilization and our inexhaustible ability to distort and pervert everything in our environment and our lives that is natural and good. It is not only a philosophical perspective but he describes in minute detail how it all comes about and why it is the cause of practically all the diseases that we are treating today.

Dr. Garten has some very interesting information pertaining to the controversy about benefits and objections to use of cow's milk as human food. His observations were probably the most significant of any that has come to our attention. There just may be better ways to get the human needs for calcium than cow's milk, but the issue is not, however, completely closed.

Another attention-demanding factor in this book, along with many others, is the possible metal toxicity of dental amalgam. Some of these metals are highly toxic and their use is cited as producing serious clinical problems from skin rashes to serious neurological disorders. He relates how Russian research has measured the galvanic current produced in the human mouth which may release toxic metals in the amalgam such as mercury, and cadmium and others. The clinical evidence which he relates calls for research into this aspect of systemic toxicity. In conclusion, this is a valuable book, one which will enhance the value of your services. □

Ralph J. Martin, D.C.

Continued from page 13

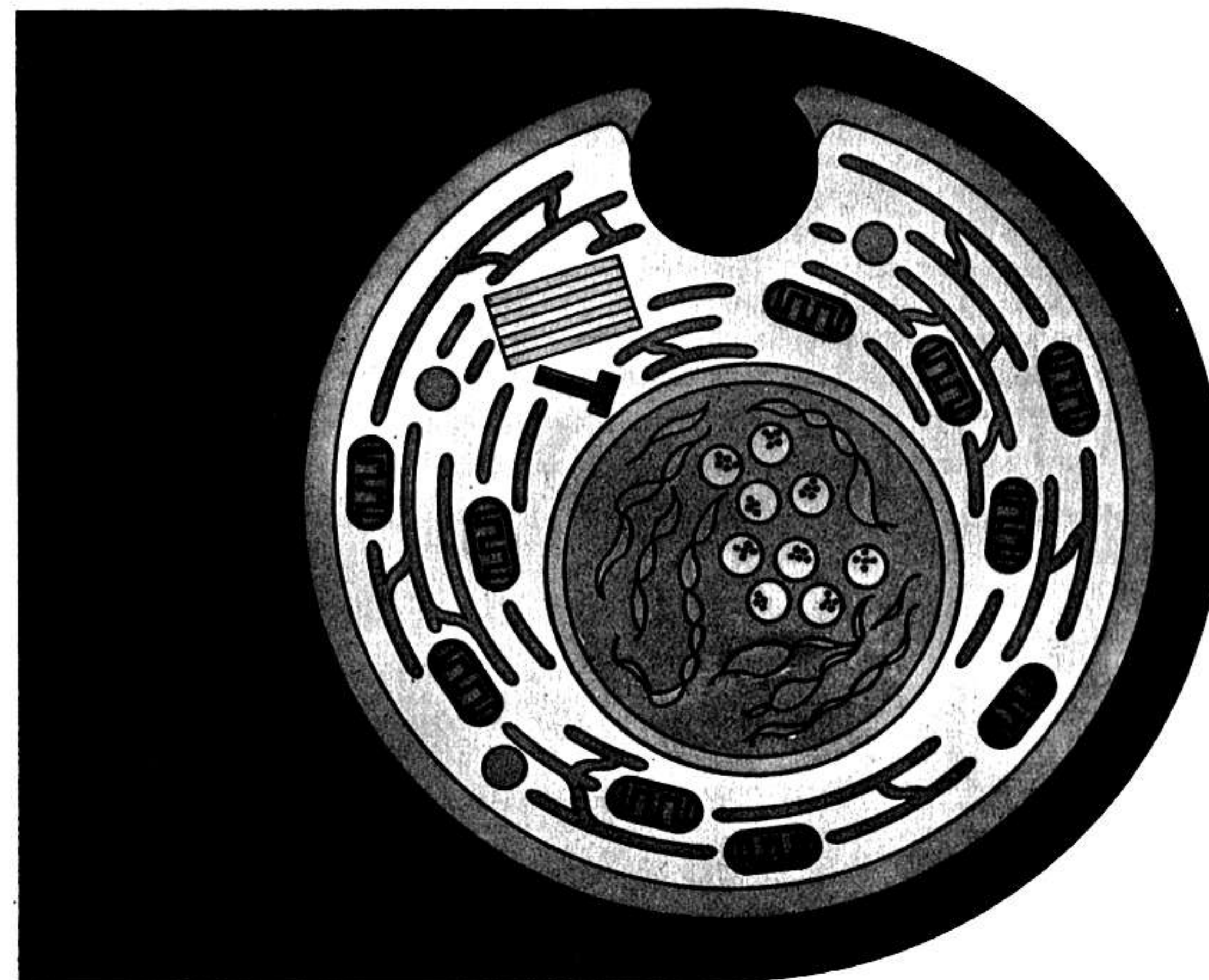
pattern would produce hyperventilation and that her cooperation would be necessary to improve it. She did her best and did become more emotionally stable with improvement in the respiratory pattern. As all signs and symptoms pointed to flu as being her illness, that was my diagnosis.

This girl had never had manipulation treatments before so she was somewhat apprehensive about what was going on as I began her adjustment. This subsided as soon as she realized that she was not going to be hurt. She was given a thorough adjustment with special attention to the 7th cervical, atlas, axis and all areas of contraction of her spine where there was found to be tension with either pressure technics or gentle stretching. Clavicles were raised; scapulae were loosened, and there was a gentle springing of the ribs. After about ten minutes of manipulation the patient was breathing much easier. At this point I started her on 1000 mg. of vitamin C, 500 mg. every waking hour with a glass of water. I started the cool compresses to her throat and neck and to her head but nowhere else. In about an hour the treatment was repeated. The temperature was still 104 degrees but I felt the heart sounds were a little better. I had no intention of leaving this patient until I had ruled out to my satisfaction either pericarditis or endocarditis. I stayed with her until 1:30 A.M. I adjusted her a total of four times in this period. My adjusting table was an ironing board placed between two chairs. I might add that when I left, the patient was sleeping soundly.

I went back in the morning before I went to the office and adjusted her again. However, I did not spend any time examining her as she seemed definitely better. I went back that evening after office hours and she was doing well and the heart sounds were clearly definable. I was not too concerned about that any longer. The temperature was still 104 degrees. The parents were very much concerned about the continued high temperature but they did not realize that it was only 24 hours since I first saw the patient. They wanted to give her aspirin to combat the fever. This I forbid them to do and I did the best I could to explain why the fever was necessary and that it probably would last three or four days. I explained that the cool packs would keep the girl as comfortable as would be necessary. She was also bathed twice daily with warm water. Her diet consisted of broth and fruit juice. Her bowels and kidneys were functioning well. She was still on the vitamin C regime. I made a total of seven calls on this patient. The last two may have been unnecessary but I wanted to be on the safe side and sure the chest sounds were acceptable. The next time I saw the young lady, she came to my office and she was completely asymptomatic and was a very happy patient.

The nice thing about this case is that even though the father did tell me "Doc, I can't pay you now. I will do the best I can to give you a little at a time whenever I've got it." I did not make a big issue of this situation. This man's employer, a man I had never seen before in my life, came into my office and expressed his appreciation for what I had done. He said that he was glad there was still a country doctor left in town who would make a call like that. Since that time this man has referred four cases to me; each case an infectious condition that would not ordinarily be sent to a chiropractic physician, but even though he knew that he could not have cared less, as he knew what I could do. This shows that if you are not careful you can be tabulated either as the guy that people go to for a crick in the neck, or you are the physician that they go to when they are feeling ill in any way. □

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LETTERS TO THE EDITOR

The Chiropractic FAMILY PHYSICIAN

Although I am no longer in active practice, I do subscribe to your efforts to promote Chiropractors as First-line Health Practitioners: Physicians. Too many of our colleagues limit themselves, to the detriment of our great profession. I would like to submit the following experience — a case of previously unrecognized viscerosomatic reflex.

In August of this year, a good friend and his wife flew to San Diego from Lombard, IL. Having only recently recovered from a massive heart attack, we felt he should not be expected to drive the 550 miles to our home, so we drove down to San Diego to pick up our friends. I was shocked to find this 60 year old man walking awkwardly, and with great difficulty; and when standing, he leaned his back against whatever was available.

I learned that he was suffering severe pain in his lower lumbar region and around the right hip joint. He had been going, regularly, to a Chiropractic Clinic in Lombard for several years, with only temporary relief. His condition was slowly deteriorating, and it took great effort to go to work.

He was happy to accept my offer of help. I found a great deal of irritation in the areas of the descending colon and the internal rectal sphincter. My treatment was concentrated in these areas, with supportive areas included. With the second treatment, he was free of pain. By the fifth treatment, he was so busy sightseeing, climbing hills and stairs, that I had difficulty giving him two more treatments during the second, final week of their visit. At last report from them, he is free of pain, and admits to enjoying going to work. (He is a carpenter). □

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POISONS IN SLUDGE FERTILIZERS

Reprinted from CCA Journal

FERTILIZERS MAY CAUSE KIDNEY DAMAGE

RIVERSIDE — The home gardener who has "gone organic" may have more contaminated produce on his dinner table than the supermarket shopper.

Repeated and long use of certain "organic" fertilizers and soil amendments made from sewage sludge may lead to unsafe cadmium levels in produce, says Al Page, soil scientist at the University of California, Riverside, and director of the Kearney Foundation of Soil Science.

Kidney damage can result if excessive cadmium is ingested steadily for 10 to 20 years. Cadmium, a heavy metal that occurs in variable amounts in sewage sludge, is absorbed by vegetables in sludge-amended soils. Homeowners and the turf industry use sludge-based fertilizers, whereas most commercial growers do not.

As with tar and nicotine from cigarettes, cadmium has cumulative health effects. Medical sources say 3 to 10 percent of what is eaten remains permanently in the kidneys.

Not all sludge, the solid component of wastewater, contains harmful amounts of cadmium. But homeowners will find there is no requirement that cadmium content, or even the source of sludge, be listed on the package.

Page says that cadmium is retained by the soil, as well as the body, and could become a greater problem as time goes on.

"More than 99 percent of cadmium and other heavy metals stay within one yard of the soil surface over a 10-year period," he explains. "Our major problem now is predicting what will happen to it in 10, 50 or 100 years."

To that end, UCR scientists Garison Sposito and Shas Mattigod have devised a computer model to predict what happens to cadmium after it takes up residence in the topsoil. Depending on several factors, a variable percentage of it will become available to plants and so a potential contaminant.

"The computer model is a breakthrough," says Page. "We can now do in microseconds what might otherwise take days or months."

The predictive method is an adaptation of a general-purpose computer model developed at the California Institute of Technology. It will be published soon by the U.S. Environmental Protection Agency.

When should the home gardener begin to worry about cadmium contamination?

"Some scientists say there would be a health hazard to a family eating most of their vegetables from a garden fertilized for 10 years with a sludge product relatively high in heavy metals," the UCR scientist says.

But the actual threat to any one individual is dependent on many variables, for instance, vegetables in the diet. Leafy vegetables absorb much more cadmium than

Continued on page 29

EXECUTIVE DIRECTOR'S REPORT COUNCIL ON DIAGNOSIS & INTERNAL DISORDERS

William A. Nelson, D.C.

It was an exciting annual meeting in Seattle. We met some of our members for the first time and had a stimulating dialogue during the business session. After all the smoke cleared, we found we had some new officers to guide us for the next year. President is Eldred Wilson of Slater, MO. Vice president is Ronald Sibson of Bakersfield, CA. Secretary is Richard Tyler of Vermont. Exec. Dir./Treas. continues to be William Nelson of San Francisco, CA. The fifth member of the Executive Board is our new past president Casmer Nedzweck of Detroit, MI.

SUPPLEMENTAL REPORT TO HOUSE DELEGATES

We wish to clarify our programs and goals. Our purpose, simply, is that chiropractors should be recognized as physicians.

We realize some chiropractors may not wish to assume the responsibility of a physician; this is okay with us. Unlike the recent destructive minority we do not create a Procrustean bed to which everyone must conform. We are diametrically opposed to the ideas of Sherman and Adio Colleges that would constrict chiropractic to fit their narrow and death inducing ideas.

We believe chiropractic is a natural science and as such must conform to the laws of nature. It is an absolute law of nature that a body must grow or die. If there be not growth, then there is death. Physiology tells that stasis is death.

Our definition of chiropractic is as broad as nature. It involves all our speciality councils, specifically includes unlimited diagnostic potential and avers that chiropractic can and does influence the internal viscera for whatever value this may be.

We well realize we are too liberal for some of you. Some will say acupuncture and nutrition are as far as chiropractic should go. Another will say kinesiology is chiropractic but not hypnosis.

Our answer to such limiting statements is, "You are defying the law of nature, by limiting natural growth you are courting death." Only by permitting this profession to grow as future years may determine do you assure future generations of the benefits of chiropractic.

Our growing membership is impatiently waiting for ACA to throw off the shackles that bind us to the spine. Now that you have experienced the terrible insult handed to CCE and everyone of us by the proponents of spine only, perhaps you can better see the imperative need of opening chiropractic to the nervous system. The Council on Diagnosis and Internal Disorders respectfully asks your serious consideration to open the window, let in the light and permit this profession to take its rightful place in the natural sciences by letting it grow.

To grow, it must not have unnatural restrictions placed upon it. Our people must be recognized as physicians, many will be family physicians, some will specialize, but we all will be classed as truly primary care health providers.

This, our colleagues, is what the Council on Diagnosis and Internal Disorders is all about.

Another plus — You will begin noticing that ACA public relations will show chiropractors as family physicians or general practitioners. □

INTERPRETATION OF CYTOTOXIC TEST

Gerald E. Stavish, Ph.D., D.C.

Since this is a laboratory procedure, toxic substances which could not be tested safely on a patient, can be evaluated as to sensitivity. This test has correlated well with individual positive, provocative test reactions as we have performed them over the past several years. After the fasting and feeding program, there has been a lesser degree of correlation between positive tests. This is probably due to rapid establishment of tolerance.

The results of the test are recorded as: negative, one, two, three, four plus or hyperactive. A negative test indicates no cellular changes. One and two plus represents two different degrees of paralysis of the white blood cells, three and four plus indicate two different degrees of actual destruction of white blood cells. Hyperactive indicates increased cellular activity. In especially severe reactions there are changes recorded in red blood cells and blood platelets. This may be recorded as RBC crenated or diminished blood platelets.

This test has to be interpreted in relationship to the frequency of exposure. As an example: positive reactions to foods consumed every three days or oftener, can be significant even if only graded one plus. Foods taken only once a week or less often, which show positive reactions, usually do not cause symptoms when consumed with this spaced frequency. You may continue to take these foods at spaced intervals but you are not to increase the frequency of their consumption. A hyperactive reaction is often observed in a food taken infrequently which has caused symptoms in the past. This test certainly reveals reactions similar to allergies but really shows which foods, etc. literally and visibly poison the leucocytes — which are really the activators of the immune system — hence they are contributing factors in the diseases inadequately resisted by the patients. Also its red blood cells are affected. Their membranes become rough and they appear mushy; hence they can contribute to formations of blood clots (thromboses, heart attacks, strokes, and thrombi in the extremities).

The first part of the leukocytotoxic test sheet has fifteen groups of three commonly consumed foods. The last six groups include fourteen commonly encountered environmental chemicals. The first five are encountered in fabrics, in floor coverings, or clothing. Newsprint exposure from the fumes of solvents associated with the ink appears to be an increasing cause of trouble. Soy and Karaya gum are often associated with this exposure.

Phenol or carbolic acid is in coal and wood tar. In dilute solution, it is an antiseptic found for example in Lysol and Pine-Sol. As a phenolic resin, it is found in food can linings. Half of the total production of phenol is used in the manufacture of plastics and one fourth in the production of drugs of coal tar origin, such as aspirin and sulfa drugs. It is often used as a preservative in many injectable medications including allergenic extracts. Thus it is an important environmental exposure in the home, in food, in the air, and in medications. It is tested in 1 to 5 serial dilutions and paradoxically more severe reactions often occur with weaker than with stronger dilutions. The 1, 3, and 5 refer to 1:5 serial dilutions; the 3 is 25 times weaker than the 1, etc.

Ethanol used in these tests is made from ethylene gas by the oil companies. "Petrochemical (synthetic) ethanol is an excellent solvent for the numerous sen-

Continued on page 25

sitizing, irritating and/or toxic hydrocarbons present in crude petroleum and its almost limitless derivatives to which man is constantly exposed. Many individuals who become ill from chemical additives and contaminants in food and water, in addition to fumes and combustion products of petrochemicals will react to the small quantities of hydrocarbons dissolved in synthetic alcohol."

The 1, 3, and 5 below ethanol refer to the serial dilutions as described under Phenol. Smog and auto exhaust fumes are one of the most common exposures related to synthetic ethanol. Provocative ethanol tests confirm sensitivity to these various exposures. Neutralizing ethanol drops are often very effective in controlling induced symptoms.

Clorox is a test for chlorine sensitivity which may result from bleach or chlorine in drinking water.

Fluoride is tested twice because it is tested in two dilutions. Positive reactions are apparently most often associated with the fluoride in toothpaste and next in water.

F.D. & C. certified colors are often associated with adverse reactions. The most common adverse reactions are the yellow dye known as tartrazine #5 which is found in many foods, such as jello, soft drinks, and drugs. Next in frequency are the red dyes.

CYTOTOXIC TEST CODE

Negative 0	Viable normal appearing neutrophils and platelets in all fields examined
Questionable +	Less than half of the neutrophils round and inactive in 10-15 fields examined
Slight ++	Slightly over half of the neutrophils round with inactive amoeboid movement and diminished streaming of cytoplasmic granules.
Moderate +++	Neutrophils round. Some vacuolated or disintegrated. Eosinophils and lymphocytes resistant. Red cells may show mushing or crenation.
Marked ++++	Majority of neutrophils disintegrated. Platelets diminished with clumping or disappearance.
Hyperactive	Neutrophil pseudopod activity appears to be increased.

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- a. Evidence suggests that HDL plays a role in *decreasing* total body cholesterol by depleting cholesterol from the tissues and being involved in transport to the liver to be catabolyzed and/or excreted in the bile. It also seems that HDL may interfere with cellular uptake of cholesterol.
 - b. Although some recommend HDL cholesterol, LDL cholesterol and triglyceride as a profile for risk factors for coronary artery disease, it seems that the best objective statistical estimate for risk is documented for HDL and total cholesterol and their ratio.
3. Serum HDL and total cholesterol and the ratio of total to HDL cholesterol minimizes the effects of technical variables including specimen handling, variables related to the fasting or non-fasting state and variations in methodology including standards. They are also the most significant laboratory findings to assess risk of ischemic heart disease. This is based upon Lipid Research Clinics — Framingham — NIH studies.
- a. Current evidence demonstrates that HDL cholesterol is the most significant laboratory lipid or lipoprotein test for estimating or predicting the risk of coronary artery disease (myocardial ischemia), in populations or individuals.
 - b. However, to date, no reports have demonstrated that if one changes the HDL level in an individual it alters the risk in that individual, except possibly for the improved control of diabetes which is more complicated than just influencing HDL levels.
 - c. Nevertheless, the evidence implies that an individual is better off doing things that increase serum or plasma HDL and lower total cholesterol. So that no matter what the level of HDL or total cholesterol, the individual should avoid excess carbohydrate, inactivity, and smoking.
 - d. It is interesting that coronary prevention programs such as smoking reduction, fat controlled diet, weight reduction and physical activity, even if *lowering* total cholesterol, they are *increasing* that fraction which is HDL cholesterol.
 - e. There still remains a great deal to learn about environmental factors which influence HDL cholesterol. The possibility that genetic factors may be important has been raised by a report that children of coronary artery heart disease parents have lower HDL concentrations than do the children of healthy parents; a phenomenon which may contribute to the well recognized incidence of familial coronary artery disease.
4. HDL cholesterol and total cholesterol seem to give the same data whether specimens are fasting or non-fasting; however, fasting lessens the incidence of turbid serum or plasma specimens. Turbidity may affect laboratory findings depending on methodology and should be avoided whenever possible. EDTA plasma is recommended for lipoprotein typing studies but seems to be no better than serum for HDL and total cholesterol studies.
- a. If the specimen is processed after blood drawing within 2 hours, the serum can be separated utilizing conventional room temperature centrifugation. If there is a delay in testing the specimen, the serum can be stored up to 6 hours without refrigeration but preferably refrigerated and then is stable for up to 7 days. A frozen serum specimen is stable for months for HDL and total cholesterol but freezing leads to an unreliable specimen for other lipoprotein or triglyceride studies.

- b. A reliable HDL cholesterol requires a day to day 2SD precision of ± 7 mg/dl within the range of 30 to 60 mg/dl.
5. Since this assay is to assess risk, the interpretation of findings is more relevant to risk rather than to the so-called normal values; therefore, both types of reference values are provided, based on literature data verified in this laboratory.
- a. Total cholesterol of less than 200 mg/dl is associated with longevity; total cholesterol is a greater risk factor in men ages 20-39 than at older ages 40-80.
 - b. HDL cholesterol in *average males* = 45; and 55 in females; <35 mg/dl = *high risk*, >55 mg/dl = *low risk*; 35 mg/dl = 8X the risk at 65 mg/dl. Some studies demonstrate 45 mg/dl as the critical level with increased risk below this value and no change in risk for higher values.
 - c. *HDL in females age 49 to 82*: 25-35 mg/dl = 3-4X risk at 35-64 mg/dl = 8-12X risk at 65 mg/dl and higher.
HDL in males age 49 to 82: 25-44 = 2X risk at 45 to 64 mg/dl = 4X risk at 65 to 74 mg/dl. Levels of 75 or more = minimal to no risk for coronary artery disease.
 - d. Total Cholesterol to HDL Cholesterol Ratio

Men	Risk	Women	Men	Risk	Women
3.43	1/2 average	3.27	9.55	2X average	7.05
4.97	average	4.44	23.79	3X average	11.05

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Studies of nucleic acid metabolism in rats by use of carbon — 14 — labeled purine and pyrimidine bases and nucleic acids. 2. Anabolic pathways of nucleic acid derivatives. Greife, H.; Molnar, S. (Inst. Tierphysiol. Tierernaehr., Univ. Goettingen, Goettingen, Ger.). *Z. Tierphysiol. Tierernaehr. Futtermittelkd.* 1978, 40(5), 248—56 (Ger). The 8—14C—labeled purine bases: adenine and guanine, as well as the 2—14C—labeled pyrimidine bases: cytosine, uracil, and thymine, were given to rats either i.v. or orally, U—14C—labeled nucleic acids were given only orally. Twenty—four h after dosing and (in a metab. trial after i.v. injection of adenine) after 21 days 14C—activity in the carcass, liver, kidneys, and body lipids was analyzed. Large proportions of activity remained in the body after i.v. injection of adenine—8—14C and after oral administration of U—14C—labeled nucleic acids. Twenty—four h after dosing the tracer, 78.4% of the activity with adenine and 19.7% with nucleic acids could be found in the body, 21 days after i.v. injection of adenine the corresponding value was 20.9%. With the other substances after i.v. injection only 1-2% and after oral dosing only 2-5% of the activity was retained in the body. The only noteworthy abs. atms. of 14C activity in the liver and kidneys occurred after i.v. injections of adenine—8—14C or oral administration of labeled nucleic acids. The body lipids were labeled of <1% of the 14C dose after administration of labeled purine and pyrimidine bases and to 1.3% of the 14C after labeled nucleic acid. The use of the purine and pyrimidine derivs. and their catabolic products for biosynthesis of nucleic acids and other compounds in body tissues is discussed, based on the above results.

As yet, we do not know specifically how this actually takes place but we do know that it happens. It is my speculation that digestion of the protein tissues and glands does take place so that only the amino component parts are absorbed. Since there is definite tissue and gland specificity in the DNA as to which amino acids are present and in what arrangement and percentage, blood that contains amino acids in the proper balance and quality for a specific gland or tissue makes it easier for that particular tissue or gland to attain the amino acids necessary for repair and building. It is all a matter of quality and quantity of available nutrients for any particular tissue or gland. If they are available in the blood qualitatively and quantitatively, the responding tissue or gland can build, rebuild or repair itself more readily according to the DNA pattern.

Thus we now see that there is a nutritional rationale for glandular therapy, that glandular tissues do provide the essential nutritional combinations required by the corresponding tissues within the body.

This recent information cited by Dr. Nittler provides us with a good basis for glandular tissue *nutritional* therapy. Really it gives new meaning to the phrase "like cures like." Practical considerations in glandular nutritional therapy would include the following:

An accurate diagnostic evaluation . . . try to gain an understanding of the physiology of disease; determine which organ or organ system is involved. For example, in stress related conditions the adrenal cortex is usually depleted. A logical therapeutic choice would be the supplement with a megavitamin dose of the water soluble vitamins (B-complex plus Vitamin C) and the nutrients found in the adrenal cortex preparation. □

To be continued in the next issue.

After the completion of the digital examination it is time for a thorough visualization. The transparent disposable anoscopes are best for this procedure because sterilization is not necessary and because of the complete visual access obtained without the need for several reinsertions.

When the complete insertion has been made the obturator is removed. Look for internal hemorrhoids, inflamed or hypertrophied anal papillae, fissures, inflamed valves of Huston at the base of the columns of Morgagni and for tumorous masses. The use of a sigmoidoscope is necessary for deeper penetration and a more complete anal evaluation.

Only by doing the preceding can you know with any degree of certainty the nature of the pain that your patient may be experiencing in the lower back. We are primary physicians and treat the entire body but we only do this by examining it as completely as we plan to treat it. □

other produce. Potatoes and wheat also absorb cadmium, and they could be a substantial source if eaten in large quantities.

Also, sludge varies in cadmium content. If it is from industrial areas, particularly where there is electroplating and metal processing, it tends to contain much higher concentrations of cadmium than sludge from a suburban area.

What scientists call the "background level" of cadmium — existing in an individual's air, water, food and soil — also varies. Soil in a residential area built on a landfill may already be contaminated. In some California areas, natural cadmium from sedimentary rocks in the coastal range may augment the effects of sludge disposal.

"We are taking cadmium out of mines, using it in consumer products and then returning it to the earth's surface, where it comes in direct contact with us. Some estimates are that the male teenager's daily intake of cadmium is near the tolerable level recommended by the World Health Organization (70) micrograms," the UCR researcher notes.

Supermarket produce, on the other hand, is unlikely to be contaminated by cadmium, because sludge-based fertilizers are used only on 1/10th of 1 percent of commercial farmland. Most sludge is not rich enough in nitrogen to be of practical value in intensive agriculture, and a buildup of heavy metals may severely depress the productivity of the soil.

But the increased disposal of sludge on land is inevitable. Growing population, coupled with more and better sewage treatment, is expected to double sludge production in 10 years. And environmental agencies are pressuring Los Angeles, among other coastal cities, to cease ocean dumping of sludge, which has accounted for 15 percent of disposal.

Heavy metals in sludge are everyone's problem. □

ANNOUNCEMENT

Classes leading to Examinations for "Qualified Internist" were started January 20 and 21, 1979. Enrollment open:

Spring and Summer Classes

Nov. 17-18

Dec. 15-16

Jan. 19-20

Feb. 16-17

This Council accepts candidates for 'Qualified Internist' or 'Diplomate Internist' examinations who have taken the required number of graduate hours of advanced clinical courses in an Accredited Chiropractic College. This Council does not engage in any educational activities outside the C.C.E. educational system.

This Council's position is that all graduates of undergraduate colleges require extensive special graduate clinical education to become Family Physicians.

We encourage all who are interested in practicing as Family Physicians with credentials as 'Qualified Internist' to organize groups of your colleagues and apply to the C.C.E. accredited college of your area to initiate such courses. Some colleges are conducting 'Residency' provisions for new graduates.

For Information, call:

Cynthia E. Preiss, D.C., L.A.C.C. Graduate School Dean
(213) 240-7686, Ext. 22

Los Angeles College of Chiropractic
920 E. Broadway
Glendale, CA 91205

All ACA Accredited Chiropractic Colleges are invited to participate in presenting classes in Diagnosis and Internal Disorders, using the Council approved Syllabus.

COUNCIL ON DIAGNOSIS AND INTERNAL DISORDERS of the American Chiropractic Association

MEMBERSHIP APPLICATION

I hereby apply for membership in the Council on Diagnosis and Internal Disorders (CDID) of the American Chiropractic Association:

DECLARATIONS:

Name _____ Age _____

Mailing address _____ City _____

State _____ ZIP _____ Phone () _____

Home address _____ City _____

State _____ ZIP _____ Phone () _____

Chiropractic College graduated from: _____

States Licensed to practice in: _____

This application is subject to approval by the Credentials Committee, and it is understood I shall be informed of acceptance. I am a member of ACA.

In becoming a member, I agree to abide by the Code of Ethics and By-Laws of the Council on Diagnosis and Internal Disorders.

My application fee of \$15.00 and first year's dues of \$15.00 are enclosed. APPLICATION FEE IS NOT REFUNDABLE. Dues will be refunded if application is not accepted.

Applicant's

Signature _____ Date _____

Check or Money Order must accompany this application, payable to:
"Council on Diagnosis and Internal Disorders" or "C.D.I.D."

Mail to the Office of the Executive Director:

Dr. William A. Nelson
760 Market Street
San Francisco, CA 94102

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Inquire, Cynthia E. Preiss, D.C.
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OF THE AMERICAN CHIROPRACTIC ASSOCIATION

THE CHIROPRACTIC FAMILY PHYSICIAN

JANUARY, 1980

VOL. 2 NO. 2



MEMBER **1980**

**Council on Diagnosis
and Internal Disorders**

of the

AMERICAN CHIROPRACTIC ASSOCIATION

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THE CHIROPRACTIC FAMILY PHYSICIAN
is published bi-monthly by the Council on Diagnosis and Internal Disorders of the American Chiropractic Association, P.O. Box 1577, Glendale, CA 91206.

ADVERTISING DEADLINE: All new display copy must be in our hands by the first of the month preceding publication. Make checks payable to THE CHIROPRACTIC FAMILY PHYSICIAN, P.O. Box 1577, Glendale, CA 91206. Currency mailed at sender's risk. All contracts are subject to approval by the editorial board. The right to reject any advertising is reserved. CHANGE OF ADDRESS: Allow 4 weeks for change of address to become effective. Give both old and new addresses, including zip codes. SUBSCRIPTION: \$10.00 per year, payment in advance. THE CHIROPRACTIC FAMILY PHYSICIAN does not accept responsibility for opinions expressed in advertisements or signed articles. No portion of this publication may be reproduced without written permission. Copyright 1979, Council on Diagnosis and Internal Disorders of the American Chiropractic Association.

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The November issue of the Chiropractic FAMILY PHYSICIAN marked the first anniversary of the official publication of the Council on Diagnosis and Internal Disorders. The mailing list has grown from 4000 to 11,500 in this very short period of time and it is with a great deal of pride that we make that statement. However, this phenomenal growth in such a short time period has not been without its problems as well as its growing pains.

This council has dared step out of the beaten path so badly worn by the strict musculoskeletal concept and widened this path by proclaiming the chiropractor as a physician, a primary care health provider, a family doctor and on an equal basis with any and all other health disciplines and certainly not subservient to the allopath.

We emphasize that the chiropractic physician does not have to step to the rear of the bus any more but simply demand and assume his rightful place in the main stream of health care.

Criticism has been recieved from those who wish to remain status quo and content with their minor role as health providers while praise has been received from those willing to accept the responsibility of a physician, knowing they have the expertise to do so. There has been the chronic critic as well as those with constructive criticism and then there has been the criticaster.

The Chiropractic FAMILY PHYSICIAN and that for which it stands has continued to grow and develop in spite of the critical minority who choose to retain their sub-standard role in the health industry. This growth has been made possible by you, our members, who are willing to stand up to be counted and saying YES, we are physicians and we can prove it. ■



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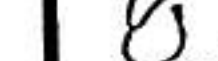
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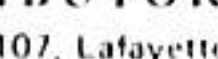
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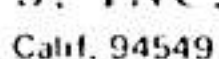
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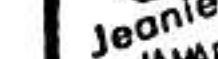
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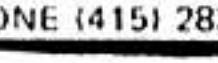
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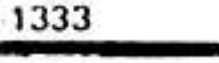
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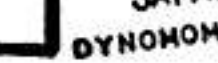
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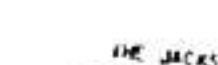
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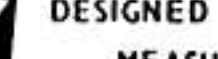
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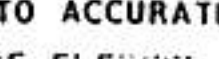
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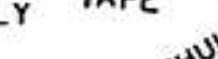
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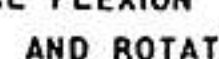
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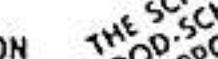
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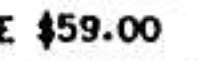
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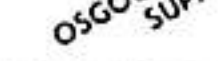
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LIST OF "QUALIFIED INTERNISTS" July — 1978

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Dr. Arthur V. Breakiron
Dr. Jeffrey Greene
Dr. R.C. Grayson
Dr. Jay D. Kirby
Dr. Harry O. Davies
Dr. Cora L. Halgren
Dr. Minnie L. Most
Dr. Mortimer Levine (Posthumous)
Dr. Ralph J. Martin
Dr. Van D. Mericas
Dr. Glenn L. Olson
Dr. Adrian Overbeck (Deceased)
Dr. Dean C. Palmateer
Dr. Richard Proctor
Dr. Casmer Nedzweck
Dr. William A. Nelson
Dr. Ronald P. Sibson
Dr. Robert J. Wiehe

American Board of Chiropractic Internists (Examiners)

Dr. Dean C. Palmeteer
Dr. Ralph J. Martin
Dr. Glenn J. Olson
Dr. Robert Wiehe
Dr. Jay D. Kirby

Alternates

Dr. William A. Nelson
Dr. Casmer Nedzweck
Dr. Harry O. Davies
Dr. Adrian Overbeck
Dr. Jeffrey Greene

PROCEDURES UTILIZED BY THE CHIROPRACTIC FAMILY PHYSICIAN

The physical examination performed by the Chiropractic Family Physician is unique in the field of health services. He not only is proficient in all the standard procedures relating to a medical physical examination but is also skilled in relating all the systems of the body to one another. He makes a distinction between the diseases of abnormal function and those of pathology. He has learned how to interpret surface findings on the body to internal disorders. He is very careful to get the patient's full history and relates the history and physical findings to guide him to determine the need for X-rays and Laboratory tests and profiles. Through his careful physical examination he usually knows where the problem is, then if tests are to be made they are for the purpose of evaluation of all physical and biochemical factors. By his very careful physical examination he is able to avoid many unnecessary laboratory and X-ray procedures which is a substantial economy to the patient and avoids excessive radiation.

The X-ray Examination

Most chiropractic family physicians have their own X-ray equipment for several reasons:

1. They have many emergency cases which call for immediate X-rays and prompt interpretation which could not be sent to independent laboratories without great loss of time.
2. Cases requiring immediate X-rays may involve possible broken bones, spinal injuries or internal crisis.
3. Many cases requiring prompt X-ray service may involve internal emergencies such as gall stones or rupture, malfunctions of the stomach or duodenum or ulcers, kidney stones and acute malfunctions, bowel crises, brain injuries and tumors. Doctors expecting to become family physicians must be trained in X-ray technics of internal disorders as well as musculoskeletal disorders.
4. The need for local practitioners to provide screening facilities is an important saving in the over-all cost of health care. Great proliferation of costs in expensive hospital facilities can be avoided by local private-office X-ray services.

Laboratory Diagnosis

1. Chiropractic family practitioners must acquire expertise in laboratory procedures and interpretation above and beyond usual undergraduate training.
2. Many will have to provide their own laboratory services; all will have to be familiar with a very wide variety of interpretative skills.

3. Frequently the family physician may be required to provide or procure preliminary laboratory profiles before he can determine a suitable specialty service for referral.
4. Experienced practitioners recognize that a very high percentage of the patients they see have problems of abnormal function rather than diseases of pathology. The chiropractic physical examination will usually clarify this distinction, but a sedimentation rate fortifies the validity of the finding.
5. Laboratory findings alone are generally recognized not to constitute a diagnosis. This is the great contribution of the chiropractic family physician "who puts it all together." He considers the patient as a person and his history and physical findings have directive influence on the X-ray and laboratory profiles so that his final diagnosis determines whether he will treat the patient himself or refer . . . which ever is in the patient's best interest.

Methods of Treatment Utilized by the Chiropractic Family Physician

1. All manipulation is to correct nerve and vascular disorders caused by structural pressure and mal-positions. The chiropractic family physician uses any form of manipulation that will provide a return of the patient's body to normal function. He may manipulate the spine, pelvis, ribs, skeletal joints of any of the extremities, or even of the skull. He will probably be skilled in highly sophisticated adjustments of the neurovascular systems which will profoundly improve the functions not only of the internal organs and systems but also of the brain and emotions. He will be able to treat defects of new-born babies and children to overcome birth injuries and defects. He will treat the elderly for high blood pressure and strokes with surprising success that is totally unheard of in medicine. He will be able to stop the vomiting of pregnancy and alleviate the horrors of menstruation which many women suffer . . . all without drugs with his knowledge of nutrition and skill in manipulation.
2. **DIET AND NUTRITION.** Nutrition and food specifics are the wave of the future in human therapeutics. As the iatrogenics of drugs and medicine are better understood and the hazards more widely known to the general public there is a great turning away from them as they have been accepted for the past century. Patients have a strongly developing attitude that "there must be a better way." He does not deny that drugs, medicines and surgery are useful but he prefers to keep them in their proper place and refer to their use as a last resort. The body should be assisted in restoring its own normal functions without the introduction of poisons from the external which often compound existing problems. When the resources of the body cannot rise to meet a crisis, we then utilize whatever measures may provide further help and assistance.

Modern nutrition involves much more than organic vegetables and whole grains at the health-food store. Nutrition involves complete balance of ingredients: proteins, carbohydrates, fats, vitamins, minerals and enzymes and in

some cases glandular products. Diagnosis and treatment of nutritional requirements demands well trained chiropractic family physicians and these cases may compose a considerable element in his practice.

3. **PHYSIOTHERAPY.** The chiropractic family physician is usually well equipped with standard physiotherapy modalities including heat lamps, diathermy, ultra-violet units, ultrasound, galvanic and sine units, vibrators and traction units. Each modality has its own special indications and contra-indications. Ultraviolet is highly effective as a bactericide. Ultrasound is an ideal decongestive agent and relieves many forms of pain. There are many special ultrasound applicators. The use of ice (cryotherapy) as an anesthesia is a very significant aid to the chiropractic family physician who avoids drugs for sedation. Sine wave is highly effective in many circulatory problems. Galvanic has a multitude of uses in infiltrating tissues with specific chemicals, or without chemicals. Dr. A. C. Johnson's latest book "Chiropractic Physiological Therapeutics" should be a ready reference to every chiropractic family physician.
4. **PSYCHOTHERAPY AND EXERCISE.** All accredited chiropractic colleges provide comprehensive courses in clinical psychotherapy for all their graduates. The Council on Diagnosis and Internal Disorders also gives strong emphasis to this field of therapy in the Syllabus required for the examinations for Qualified internists and Diplomates. Chiropractic family physicians of experience have learned that a great many of their less seriously ill patients show symptoms of lack of daily physical exercise and suffer periods of depression which are linked with failure to get adequate daily exercise. These physicians provide exercise programs which are suitable for the age and physical condition of their patients and thereby eliminate many of the less severe problems of psychotherapy.

These doctors also recognize that the mind represents the functioning of the brain and therefore provide instruments of testing of blood and fluids in the brain and treat to maintain normal fluid balance within the brain. Thereby many psychotherapeutic problems are eliminated. Concern with improvement of the physiological factors affecting the brain is also opening up a whole new field of treating expertise which not only improves the mind but also many physical ailments are benefited.

All of these things are completely within the field of the practice of the chiropractic family physician.

Referrals and Cooperation With Other Practitioners

1. The chiropractic family physician learns to know as much about all available professionals in the health field in his area as possible in regard to their competence, responsibility and reliability. This is his social responsibility so that a patient will be referred for special services to one who is not only cooperative but meets the criteria listed above. Referrals on this basis will not only enhance the status of the referring physician, but will help to build a climate of

cooperation and mutual respect among all health professionals in the community.

A STATEMENT OF POSITION of the Council on Diagnosis and Internal Disorders:

"A Chiropractor should be able to care for any condition which may arise in the families under his care, the same as a physician." D. D. Palmer, in *The Science, Art, and Philosophy of Chiropractic*, page 789. Today this is even more timely than in 1895, for now we have a long tradition of serving as family physicians and primary providers of health services. It is now particularly important that we serve as primary health providers in fact as well as in name for now most of the time there is a third party involved, either an insurance company or a governmental agency. If we drift into a scope of practice which is limited to musculoskeletal conditions third party payors will insist that we are not truly primary providers and put on pressure to down-grade us to treating only referrals from real primary providers. We are already getting pressure from all sides to classify ourselves as back technicians only and for several years have required diagnosis but deny payment, which means they refuse to recognize our experience in diagnosis. The prevailing situation in Medicare and Medicaid is intolerable and unless we assert ourselves as primary providers, in fact as Chiropractic Family physicians, we may soon wake to find that we have less professional status than the paramedics.

Only as we assert ourselves as chiropractic family physicians in every sense will we survive as doctors in any sense or substance. As back and musculoskeletal technicians our future as a profession is bleak and possibly terminal.

If we are to have a future as a professional we must awaken now to our responsibilities as chiropractic family physicians. ■

SYLLABUS FOR EDUCATIONAL HOURS REQUIRED TO TAKE THE EXAMINATION FOR "QUALIFIED INTERNISTS"

1. Educational Requirements to take the Examination for "Diplomate" Same as for Qualified Internist but in greater depth and much more clinical work and special subjects and technics.
2. Residency Course only in Accredited colleges leading to "Diplomate" status, requiring clinical residency experience in addition to attending the 302 hours of academic Syllabus above outline for "Qualified Internist."
3. Special Educational Seminars for general membership, in colleges or local regional areas.
4. Educational meetings for student units of the Council on a monthly or by-monthly basis as needed.

COURSES LEADING TO CERTIFICATION BY THE COUNCIL ON DIAGNOSIS AND INTERNAL DISORDERS

- 1st Session - 12 hours
Neurodynamics of Conservative Therapeutics
- 2nd Session - 12 hours
Physiological Factors in Disease and Patient Management
- 3rd Session - 12 hours
The Neuro-Muscular-Skeletal Factors in Disease
- 4th Session - 12 hours
Clinical Cardiology
- 5th Session - 12 hours
Cardiology and Peripheral Vascular Disorders
- 6th Session - 12 hours
Circulatory, including Lymphatic, Disorders
(Clinical considerations)
- 7th Session - 12 hours
Disorders of the Respiratory System - Lungs
- 8th Session - 12 hours
Disorders of the Respiratory System - The Upper Respiratory Tract
- 9th Session - 12 hours
Clinical Considerations of Special Problems of the Cardio-Vascular and Respiratory Systems, Examination
- 10th Session - 12 hours
Upper Digestive Tract and Gastric Disorders
- 11th Session - 12 hours
Clinical Enterology and Proctology
- 12th Session - 12 hours
Pancreatic and Hepatic Disorders
- 13th Session - 12 hours
Renal Disorders (Clinical considerations)
- 14th Session - 12 hours
Genito-Urinary Disorders
- 15th Session - 12 hours
Clinical Consideration of Special Problems of Gastro-Intestinal and Genito-Urinary Systems, Examination

- 16th Session - 12 hours
Overview of Diversified Chiropractic Techniques
- 17th Session - 12 hours
Allergies and Dermatological Problems in Office Practice
- 18th Session - 12 hours
Diagnosis and Treatment of Eyes, Ears, Nose, and Throat
- 19th Session - 12 hours
Clinical Endocrinology
- 20th Session - 12 hours
Nutrition and Malnutrition
- 21st Session - 12 hours
Dietotherapy
- 22nd Session - 12 hours
Clinical Neurology
- 23rd Session - 12 hours
Diagnosis and Treatment of the Child-Pediatrics
- 24th Session - 12 hours
Special Approach to the Geriatric Patient
- 25th Session - 12 hours
Special problems in Clinical Neurology, Dermatology and EENT.
Examination
- 26th Session - 12 hours
Techniques of Office Psychological Counseling
- 27th Session - 12 hours
Emergencies in Office Practice
- 28th Session - 12 hours
Toxicology in Office Practice
- 29th Session - 12 hours
Clinical Considerations of Musculo-Skeletal Problems
- 30th Session - 12 hours
General Seminar and Examination

CLINICAL USE OF GLANDULAR PRODUCTS

by
Peter Martin, D.C.

Continued from previous issue

Read the label! The actual glandular tissue present in the raw gland is about 12% by weight. The remaining 88% is animal fat and water. On many labels for example the quantity of glandular concentrate is stated. This figure is the 12% of actual glandular tissue substance referred to above. To illustrate, a Whole Adrenal formula may contain 120 mg. of whole adrenal concentrate per tablet which represents 1,100 mg. of the raw gland tissue.

DETERMINE THE METHOD OF PROCESSING

In order to retain the integrity of the nutritional and enzymatic components present in glandular tissues, the glandular products must not be exposed to high temperatures during processing and drying.

If salts are used in processing, their residues may render that product potentially harmful to a hypertensive patient. The chlorinated solvents used in the Azeotropic process may in the future undergo close scrutiny as possible carcinogens.

Modern processing methods, such as those used in the best laboratories and plants use no salts or chlorinated solvents in the defatting or drying processes.

Clinical comments: Develop a total nutritional approach. Use the nutritive glandular products with complementary vitamin and mineral therapy. For example, Thymus and Lymphatic concentrates may be of nutritional benefit in many infectious states, but don't forget good old Vitamin C!

Above all, remember that glandular therapy is nutritional therapy . . . that this fact is what allows its inclusion in the chiropractic armamentarium. Treat accordingly and look for healing from within rather than for drug-like hormonal response.

For further information contact Dr. Martin at 178 E. Edna Place, Covina, CA 91723 — Telephone 213/335-8652.

EDITORIAL COMMENTS

Having used these foods clinically for several decades, the first comment that I would make to the physician who is inexperienced in their use is that they are foods specifics, not drugs or pharmaceuticals, and therefore drug-like reaction should not be expected. From my observations in clinical use of these products, there seems to be definite utilization in all tissues of the body for quicker assimilation and utilization than of non-specific nuclear protein foods. While I speak purely empirically, it is gratifying now to know that recent research substantiates and supports our empirical observations.

I have always been impressed with the instinctive wisdom that predatory animals seem to show in preferring organ parts of the kill, seeming seldom to leave these choice nutrients to be wasted. There seems to be more wisdom in the selection of foods in animals which live by instinct than in man who has lost his instinctual guidance and relies on his intelligence. (?)

For the physician who has come to realize that there is more to nutrition than vitamins, minerals and enzymes, I would suggest that some extensive reading on the subject of glandular and organ foods be pursued before plunging in and using blindly.

The producers of these foods who have ads in the Chiropractic Family Physician have extensive libraries on the subject and some also publish regular monthly or quarterly newsletters, which are very informative. If there are sufficient inquiries directed to these companies it is probable that they will produce reprints of some of their early publications. Some of the early pioneers writing on these subjects are: Dr. Royal Lee, founder of Standard Process Laboratories, Inc.; Dr. E.H. Minns, founder of Besco Products Company; Dr. H.R. Harrower, founder of Harrower Laboratories, and author of "Practical Endocrinology"; and the Wiggelsworths, founders of Anabolic Food Company.

These organ and glandular products are whole organ substance in distinction from extracts which appear in drug-related products, and the action and reactions of these whole organ and whole gland foods is totally different from those of extracts. Reactions in a form of anaphylaxis is always possible with extracts, and very unlikely with whole organ and gland substance when used discretely.

In conclusion, the clinical use of organ and glandular substance is an essential aspect of the total science of nutrition and we expect to see a new and very productive resurgence of interest in this aspect of the science and its clinical application.

Ralph J. Martin, D.C. ■

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THE PERENNIAL LOW BACK

William A. Nelson, D.C.

The low back pain and spasm has plagued the healing arts for centuries. History records various methods, many of them manipulative, that have been tried with poor to mediocre results. As the various procedures were developed they were accompanied by theories to explain the occasional success or excuse the many failures. Chiropractic has had its share of both success and failure. Certainly chiropractic has probably enjoyed the greatest percent of success of any method to date. But with it all, the problem persists.

The person who attempts to move a piano alone or suddenly deflects a potentially crushing object may be presumed to have a mechanical problem requiring mechanical treatment. But, as often happens, the patient may have been merely bent over the wash basin to brush his teeth when his back went into spasm. Or simply picking up a pencil from the floor can provoke a back problem that lingers and resists correction.

It is with the seemingly unprovoked back difficulties that this article concerns itself, the cases where there is no overt trauma that can honestly be blamed for the patient's pain and relative immobility. Yet the low back is acutely painful, the patient cannot straighten up and untoward movement is scrupulously avoided.

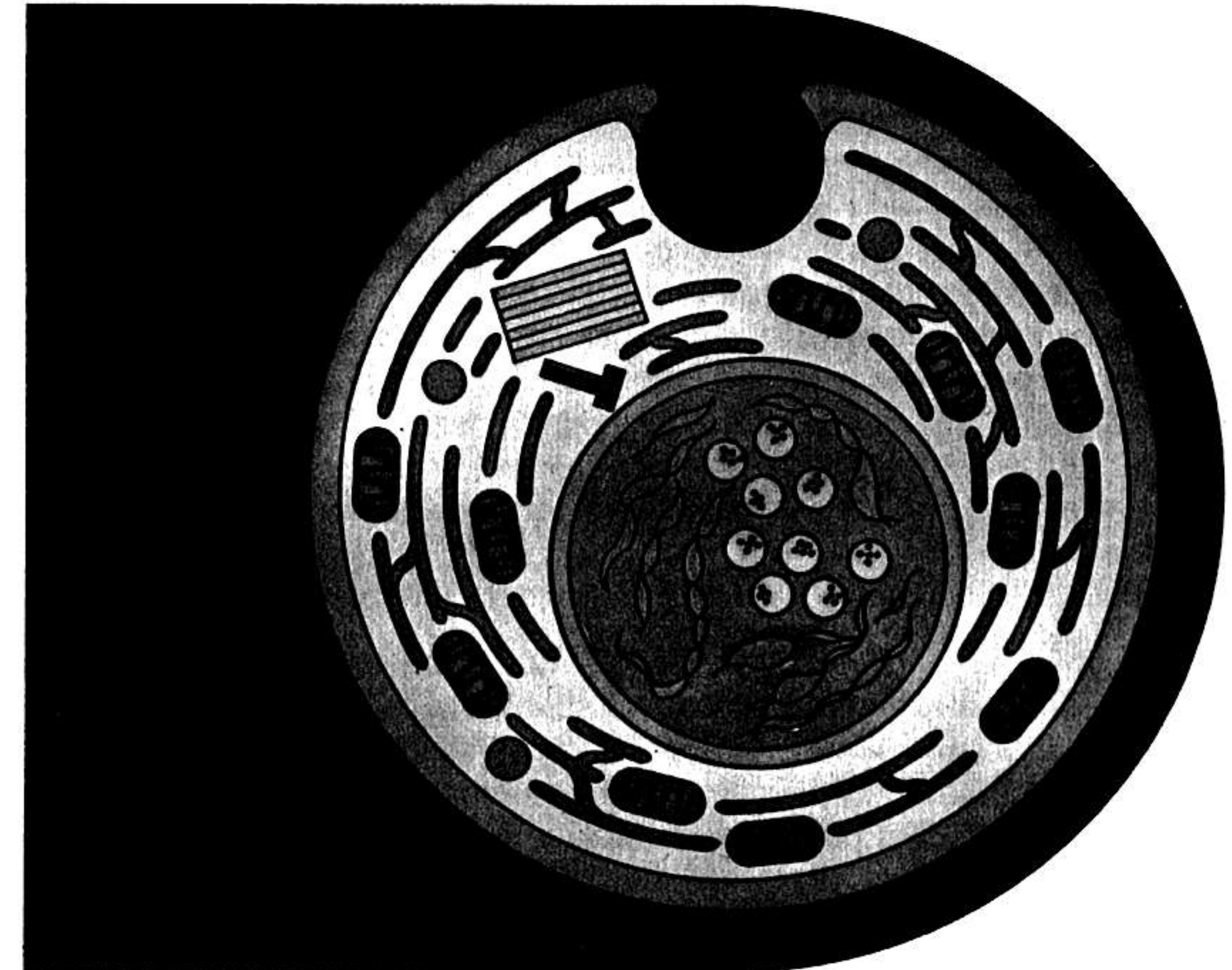
Examination in a prone position usually shows a pelvic rotation with one innominate superior. L5, and sometime L4, is subluxated. In severe cases the paraspinal muscle spasm is so intense the lumbar lordosis is lost. An adjustment of the lower dorsals will many times balance the innominates and ease the lumbar hypertension, suggesting a reflex predisposing cause.

A frequent finding and worth looking for is a tender area at or inferior to the spinous of L5. By pressing firmly between L5 and S1 a point of considerable tenderness may be found. Sometimes it is more noticeable on the lateroinferior aspect of L5 spinous. For many years this area of hyperalgesia has been recognized as principally a gallbladder reflex. To confirm a suspected gallbladder reflex, apply firm pressure on the lesser tuberosity of the right humerus. If this too be hyperalgesic, a gallbladder malfunction may be inferred.

The back will respond to therapy much faster if treatment to the gallbladder is included as part of the regimen. The physician will frequently find that as soon as gallbladder function is normalized the recurring back problems become a thing of the past. One must remember that if the visceral problem is merely functional, it will usually not be apparent by orthodox diagnosis. The proof of the pudding is in the eating, give it a try and prove it to yourself.

In establishing a management procedure for these cases one must consider therapy in a total sense. A diet to take the work load off the gallbladder such as no chocolate or dairy products. Manipulation in the upper and mid dorsal areas for gallbladder influence. Recognition of the effects of stress, appropriate physiotherapy and any other technics designed to enhance gallbladder function should be used. Attention to the low back becomes of equal but not of more importance than the vicus initiating the viscerosomatic reflex. ■

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EDITORIAL

IT'S TIME TO STOP THE CHIROPRACTIC RETREAT FROM RESPONSIBILITY

As I meet professional people in the health services I detect an effort on the part of so many to withdraw into some small restricted field of activity in which the scope of expertise and responsibility is limited. I am at a point of suspecting that this is the real reason for the decreasing numbers of family physicians on general practitioners, as they used to be called. In this field of practice they have to know so much about so many things and acquire skills of an exceedingly wide variety. In this effort they become overpowered with the enormity of the burden of their responsibility and weary and frustrated with the futility of trying to keep it all together. Finally they seek escape in some limited field which offers more financial rewards and less all-knowing scope of knowledge and reduced range of skills. This probably explains somewhat the flight to specialization of all professionals. But in health the public has a never-ending need to have practitioners of primary services — a family physician who knows the individual and considers each one as a person, not as a heart, a liver, a colon, a mind or an eye. There has to be such a person of very broad training who puts it all together for the individual and cares for the routine problems, but also knows good specialists in many fields and refers the patient when the problem is beyond his own competence.

It appears that this calls for a special kind of person who has an insatiable curiosity about human ailments and enough stamina to never tire of facing constant daily challenges which feed his satisfaction in his work. It calls for a person who has a strong empathy for people and their needs for optimum health and fulfillment. Such a person will put financial rewards secondary to the quality of his services, and will find most of his rewards in successfully meeting these daily challenges. This is therefore not a field for lazy people, either mentally or physically, for such a practice requires physical energy of the type which is self-generating and up to a point, inexhaustible.

It appears to me that unless our society can develop more people of this calibre, all health services are going to continue to suffer and the cost of malpractice insurance to escalate reflecting the public dissatisfaction with the myriads of specialists.

But, I do not reflect discouragement for I am a firm believer in the ultimate power of motivation and that education can generate motivation. I find in our colleges a profoundly low morale among the students. It seems to reflect a lack of purpose — a lack of direction, consequently a total lack of enthusiasm. If our colleges provide their students with a sense of purpose and direction, this will spontaneously generate enthusiasm.

This is not an impossible thing to undertake or to accomplish. The public in general is acutely aware of the shortcomings of the medical profession and the totally impossible confusion of pharmacology. Our colleges need not harp on this

so much as to indoctrinate students with the facts of our new science of totally applied physiology, of prevention and education of the public to avoid catastrophic medicine and its unbearable expenses. We must challenge our students to become family physicians, to dare to acquire the broad knowledge and skills required to provide a maximum service to their patients. It does not require superhuman attributes, but it does require dedication and physical stamina. Let us challenge our students not to become escapists, but to rather go after the highest rewards of providing the most complete quality of services.

Our students must be led by instructors who have experienced these achievements, for these qualities are imparted more by contagion than by the didactics of superior academic degrees. I would conclude by stating that these things can only be achieved by our colleges bringing in more professors who have tested the fruits of clinical achievement and impart it to their students by their enthusiasm for the lives they themselves are living. ■

Ralph J. Martin, D.C.

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CLINICAL ROUNDTABLE

Eugene J. Kraemer, M.T., D.C.

The Laboratory & the Physician

1. What is laboratory medicine?

Laboratory medicine or clinical pathology was born of practical necessity to divide the total art and science of medicine into manageable fields for practice and study. It is now used for clinical data essential to diagnosis, prognosis and treatment.

2. Why should the physician get better acquainted with laboratory medicine?

Even though the laboratory originated in the physician's office at the beginning, it later moved to the hospital and finally to the private laboratories. Today not too many offices have large clinical laboratory services, and most of their work must be sent out to a reference laboratory due to the complicated performances of the tests. Therefore the physician has to acquaint himself with new procedures and tests available, yet most of us do not consider it necessary to do so because we think we can do it without the above help, thus making a very questionable diagnosis.

3. Who is available to assist in the interpretation of these procedures?

Any physician who has been specially trained in the field of laboratory diagnosis is able to answer any question you have and make appropriate recommendations for your benefit.

4. When should laboratory tests be used?

Any time you're in doubt as to your diagnosis.

5. Why should the laboratory be used?

So that your diagnosis can be confirmed, or that further studies are indicated.

6. Is it essential to have a laboratory in your office?

ONLY if you are qualified to perform tests necessary for your diagnosis, and if you become a member of a proficiency program, and pass all the requirements as laid down by law.

7. What books should you use to interpret any tests?

The Laboratory in Clinical Medicine (Halsted) Saunders
Clinical Laboratory Methods (Bauer), Mosby
Interpretation of Diagnostic Tests (Weller), Little & Brown Co.
The above are all excellent books, and you should have them in your library.

SIGNIFICANCE OF "NORMAL" LABORATORY TESTS

Physicians who utilize laboratory tests and profiles as an important element in the diagnostic process are faced with the perplexing results that all findings are normal or marginal in most of their cases. This may cause the patient to wonder if having the tests run was an error in judgment of the physician, or even wonder if they were done

just to build up the total fee for services. Both assumptions are totally wrong but there is no question that normal results throughout a patient's profile does place a definite responsibility on the physician to make an explanation of such results to himself and to his patient.

To find the solution to this dilemma it is necessary to go back to the basic fact that the patient came to the physician because of one or more symptoms or at least from some concern about certain aspects of his health, energy or something that was puzzling him and needed to be reassured or to have an explanation to his concerns. The usual shrugging off of the normal laboratory tests and profiles with the easy answer that "nothing is wrong . . . go home and forget it, or it is all in your head, your imagination, or go to a psychiatrist or an acupuncturist" is blatant copping out. The patient's concern that brought him to the physician must be balanced off with the fact of the 'normal' tests and findings in the profile. This apparent contradiction has not been easy for the physician to see because it is so obvious. 'Normals' in laboratory tests are not normals in relationship to function, they are 'normal' in relationship to pathology. This is one reason for always doing a sedimentation rate test as an essential part of most laboratory testing. Since it determines whether there is **any** active degenerative process in progress in the patient's body, it is a valuable verification of the other 'normal' findings. If there are 'abnormal' (pathologic) findings the sedimentation rate provides some indication of the extent and progress of the pathology.

The answer to the 'normal' laboratory findings must be a positive one. Here is the suggested position to be taken by the physician which is positive and provides hope and confidence for the patient and responsibility and an honest challenge for the physician: "The laboratory profile and testing which has been done shows that you have no pathologic disease, that you have nothing to worry about in that respect, but these tests have no bearing on the functioning of your body. They do not tell us anything about whether any part of your body is functioning normally or abnormally, in the absence of pathology. Since you have symptoms or are at least concerned, we must assume that while you have no pathologic disease anywhere, you must at least have some detectable or measurable abnormal functions. Thus the laboratory tests which show 'normal' findings, seem to narrow the field of diagnostic investigation. We now know that since there is no pathologic disease we are looking specifically for evidence of abnormal function. This does not mean that the symptoms are any less real, or if there is pain that it is any less than it would be if there were pathology. In terms of the overall prevalence of pain, there are probably many times more people suffering from abnormal function than from usual forms of pathologic disease."

The detection and diagnosis of abnormal function is done mostly by means of the physical examination, especially of the surface areas of the body in association with balance and structural considerations familiar to chiropractic physicians. Some other testing procedures are being developed and utilized for various abnormal functions such as the under-arm temperature for thyroid function. X-rays of gall-bladder often show abnormal function rather than pathology or cholecystitis. X-rays of the esophagus often show abnormal function rather than pathol-

ogy. Hyperactive alimentary conditions are frequently visualized in which no pathology is found. Most of the common tests of the eyes by optometrists are used to find and evaluate abnormal function rather than pathology. Audiometric testing may find either pathology or functional hearing problems. Transillumination of the sinuses reveals abnormal congestion which is usually more involved with abnormal function than with pathology. These facts are mentioned not to list all such tests for abnormal function but merely to point out some of the common tests which are already in general usage.

In general, however, the field of testing and measuring in the areas of abnormal function is in its infancy, and much more needs to be investigated and tested to more accurately evaluate the presence and extent of abnormal function.

When properly explained, laboratory test results which are normal in relation to pathology can have a very beneficial result to the patient. After learning that their problems are in the area of abnormal function, not pathology, the patient experiences a great sense of relief and are released from apprehension and anxiety of grave concern. They realize that abnormal function is going to be much easier to cope with and success more assured. This places a responsibility upon the physician to learn as much as possible about the treatment of abnormal function. ■

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BOOK REVIEW

"OSTEOPATHIC MEDICINE"

Several years ago I went through a period of madness. I entertained the ridiculous idea that I would write a book — or at least edit a book that would be a comprehensive compendium of chiropractic concepts, diagnostic procedures and therapeutic approaches. This temporary insanity lasted long enough for me to fix up a file and start writing and collecting material. I was overwhelmed with waves of disinterest from my profession. I had plenty of assurances from potential contributors but after promising material they just never "found the time" to send it in. With one notable exception, the purveyors of different adjustive techniques never even bothered to answer my request for even the most cursory information. It was suggested by one that I take their course if I wanted to find out anything about the technique. Clearly, as with too many of us, the most important thing was personal financial gain rather than giving so that the profession could gain. I'm not trying to portray myself as some kind of puritan who's against earning an honest dollar — it's only when greed becomes so pervasive that nothing is done without the promise of the almighty buck that I begin getting tense.

While there might be therapeutic variations among the individual practitioners within the osteopathic profession — "officially" there is a cohesion that is enviable. Undoubtedly the most viable testimony to this fact is the text first printed in 1969 entitled "Osteopathic Medicine". It is edited by three men who contribute along with 29 others, to 52 chapters. The book is divided into two parts. Part one is entitled "Basic Precepts". This is further subdivided into 6 sections covering the espousal of osteopathic principles and their rationale supported by physiological fact and research. We often complain that we use adjustive therapy mainly because it has proven clinically efficacious. While it may not be the definitive work in this field the text goes a long way to explain, without the prejudice of a specifically promulgated procedure, why the maintenance of structural integrity is so necessary to the continuance of optimum health and resistance to pathology. There are times when you could insert the word "chiropractic" for "osteopathy" and feel that you are reading a chiropractic volume. This section alone is worth the price of the book.

Part two deals with "Clinical Procedures" and it is quite gratifying to see the adherence to manipulative concepts that permeates the text. It is almost analogous to reading a chiropractic Merks Manual.

For the purist nothing will satisfy but adherence to dogma. For the rest of us the book "Osteopathic Medicine" is a 765-page fully indexed exercise in education and common sense. The book is 10 years old at this writing and I realize that many may already possess it. If you do — read it again. If you don't — get it. ■

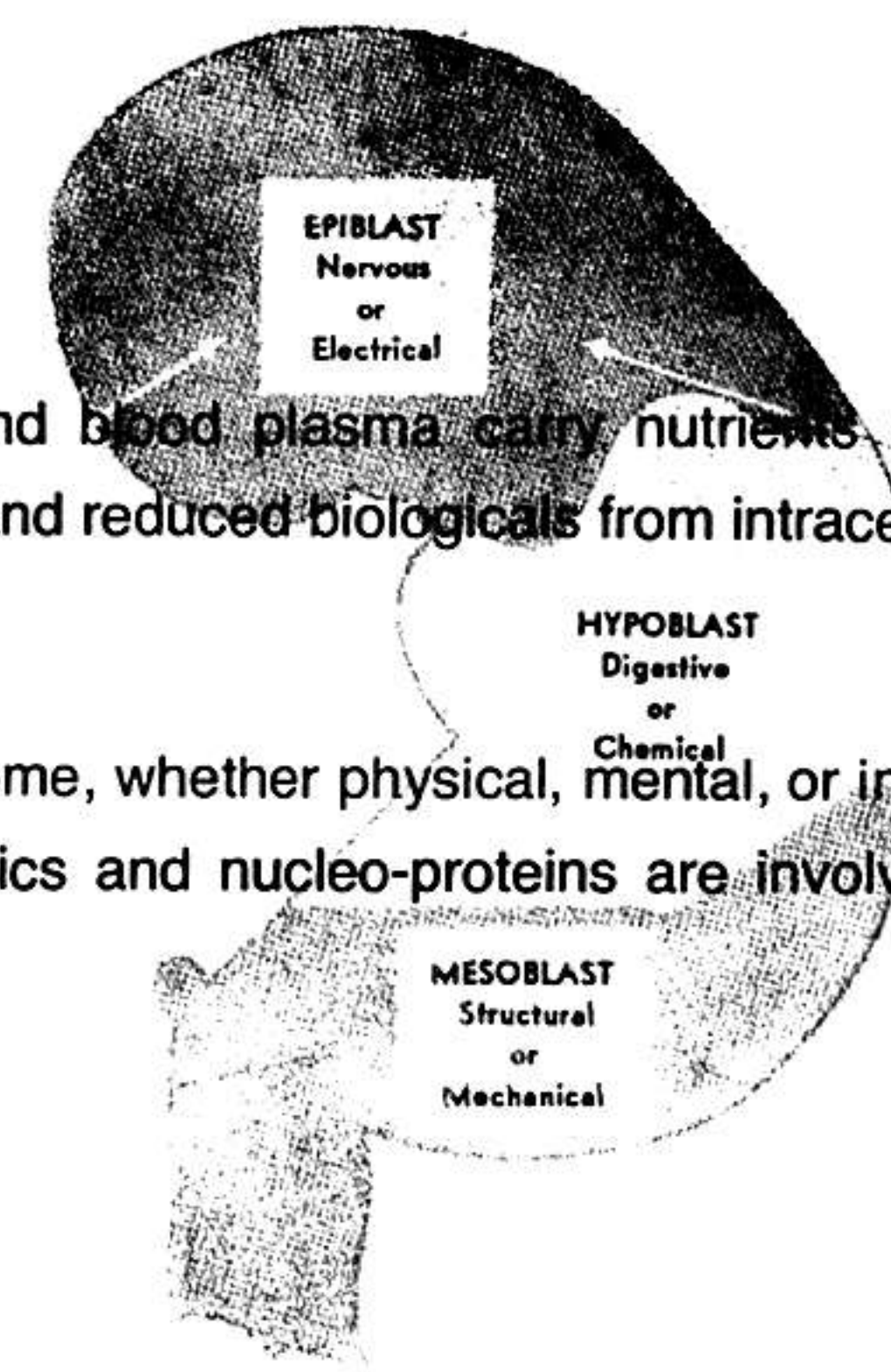
by
Richard H. Tyler, D.C.

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POWERFUL TREATMENT OF VIRUS DISEASES POSSESSED BY CHIROPRACTIC PHYSICIANS

There were published reports in 1977 on the discovery of powerful defense factors against virus infections which were called 'interferons,' found at that time to be effective only when produced within the body of the host. Early efforts to introduce them into the patient's body were completely unsuccessful. People who had successful resistance to viral infections were seemingly those who enjoyed normal systemic functioning and were therefore able to maintain adequate 'interferons' to suppress the viral invasions. It appears that within 12 to 48 hours after intracellular viral infection, when multiplication has reached its zenith, it is rapidly brought to a halt by 'interferons,' which is a protein substance produced by the infected cells.

It is believed that all cells have the potential capacity to produce this substance, but they do not produce it unless there is a viral invasion. There seem to be many varieties of 'interferons' but their common property is their ability to inhibit the replication of viruses.

Some knowledge of interferons has existed in research for the past twenty years or more, but since it could not be successfully injected or used orally to produce anti-viral effectiveness it had gained no practical clinical significance. Due to the discouraging lack of results from synthetic antiviral agents, there is now renewed interest in these natural substances which suppresses viral activity. It has become the subject of investigative excitement of virologists, microbiologists, immunologists, geneticists and cells biologists. It has been stated *that it could become one of the most versatile therapies in medical history.

Interferons was first isolated in 1957, by Dr. Alick Isaacs and Dr. Jean Lindenmann at Britain's National Institute of Medical Research. There had been some progress in research in the past two or three years inasmuch as it can now be used to treat a common cold at a nominal expense of about \$2000 per case, and it is estimated that it would cost billions to produce one pound of the substance. These figures seem to indicate that two or three trips to the chiropractic family physician would be the treatment of choice, even if there was no insurance involved. Producing adequate interferons to overcome the virus are about the best prospect in sight.

As one looks at the history of chiropractic, those of us who still so clearly remember the world-wide influenza epidemic of 1918, we recall that great numbers of cases that were given up to die by medical doctors were treated successfully by chiropractors and many of such cases are still alive today. From what we now know about interferons, it seems clear that those early chiropractic physicians were apparently doing a pretty good job of stimulating their patient's bodies to produce the badly needed 'interferons.' Statistics are plentiful to show that the virus diseases are outstripping all others in terms of prevalence and in economic cost to society. This certainly gives our chiropractic profession a vast opportunity to demonstrate what can be accomplished in the expert and judicious utilization of our all-natural methods.

*Readers Digest, Nov., 1979

**"The Horizons of Health"

GUIDELINES for AUTHORS Contributing to The Chiropractic FAMILY PHYSICIAN

The Chiropractic FAMILY PHYSICIAN solicits professional articles which are clinically oriented in either diagnosis or therapeutics of constitutional or systemic disorders. We are as concerned to recognize abnormal functions as well as pathology in both diagnosis and treatment. We recognize that very little attention has heretofore been directed to abnormal functions as distinctive from pathology. As to preventive therapeutics, it seems to be obvious that by turning our attention and our efforts toward restoring and maintaining normal physiology, most of the important aspects of prevention are adequately provided.

We intend to furnish the doctor of chiropractic who reads this Journal sound clinical information which will enable him or her to work effectively in practice and to gain new information which will give them the confidence to accept and successfully handle a wider scope and range of cases than would have been possible without this Journal. The Journal will feature a 'Clinical Roundtable' and invite practicing doctors to contribute written or taped cases they have taken care of which may help other doctors with similar cases. We believe that a great number of doctors have evolved, through their clinical experience, valuable information which should be shared with their colleagues. This Journal is essentially clinical with as much emphasis upon diagnosis as upon therapeutics. Technical non-clinical articles must have obvious clinical applications.

If manuscripts for the 'Clinical Roundtable' are somewhat unpolished, the Editor will reserve the right to 'polish' them enough to be creditably readable. Scientific articles will be expected to be written as the author would want them to appear in the Journal. All manuscripts must be neatly typed and spelling carefully checked.

Please consider this as our invitation to you to assist us in promoting the advancement of chiropractic. It is increasingly imperative that we be recognized as true portal of entry physicians. By the type of articles we have indicated above, we will be encouraging the field practitioner to expand his or her practice. We need your help in this educational process with your good articles. Please join with us in this effort to advance our profession.

The Editor
The Chiropractic FAMILY PHYSICIAN

SUPPORT OUR ADVERTISERS

"THE DIAGNOSIS AND TREATMENT OF NEUROVASCULAR COMPRESSION SYNDROMES"

by
Richard H. Tyler D.C.

With the possible exception of problems of the lumbosacral spine, the cervical and shoulder-arm area experiences the greatest number of complaints. How often have we all heard distressful stories from patients about the pain and discomfort felt in the neck with that familiar accompanying pain and paresthesia in the arm. Too often we tend to leap to the conclusion that a subluxation in the cervical spine is the cause. After palpation and an adjustment there are those who feel that relief should be virtually instantaneous. Of course this is not always forthcoming. It is therefore **before** any adjustive procedures are instituted that a proper diagnostic evaluation must be made.

A Davis X-ray series of the cervicals should be taken to rule out any possible anomalous osseous conditions that might predispose the neck and shoulder to the symptoms the patient experiences. Particular attention should be directed to discerning the appearance of enlarged transverse processes, pseudarthrosis or cervical ribs in the lower cervical spine. It is in this area that the thoracic outlet for the brachial plexus is located. These nerves, along with the subclavian artery, whose branches help form the radial pulse, pass through the scalene triangle formed by the scalenus anticus muscles anteriorly and the scalenus medius and posticus posteriorly. The neural and vascular structures then pass beneath the clavicle and above the first rib. They proceed to pass under the pectoralis minor muscles which originate near the costochondral articulation of the 3rd, 4th and 5th ribs and insert at the corocoid process of the scapula. The scalene triangle could be too small, the space between the clavicle and the first rib too narrow or the pressure between the pectoralis minor muscles and the ribs too severe causing aberrant constriction upon the artery and the brachial plexus resulting in pain and paresthesias.

The X-ray should determine any osteogenic cause of the cervical spine distress. This should be followed by Adson's maneuver in which the radial pulse is taken while the patient sits with the shoulders back and the head turned to the side of the pulse. He is then instructed to take a deep breath and hold it while tensing his chest and neck muscles. A marked diminution or cessation of the pulse would be an indication of a possible Sclenus Anticus Syndrome. This is followed by Wrights test in which the pulse is taken while the arm is abducted from the body. Again, a diminution of or cessation of the pulse is an indication of an aberrant compression this time from the pectoralis minor muscles. The final test is performed to see if there is excessive costo-clavicular pressure. The patient pulls back both shoulders, takes a deep breath and holds it, tenses the chest and neck muscles and flexes the chin to the chest while the bilateral pulses are taken.

It is only after all of the above have been performed that it may be assumed with any degree of certainty that there is no thoracic outlet compression that is causing the patient's symptoms. If any of the tests have a positive response I give the patient written instructions on specific breathing exercises which often give a measure of symptomatic relief.

BREATHING EXERCISES

Certain breathing exercises have proven quite effective in relieving the symptoms acquired from an excessive amount of pressure on nerve and vascular structures in the region of the neck.

The following exercise is simple and easily performed. It should be done upon arising in the morning and just before retiring.

1. Lie on your back on the floor.
2. Breathing through your nose inhale slowly counting as you do until you reach the count of **six**. Your lungs should be as full as possible.
3. Hold the breath for a count of **twelve** — if you can. You may have to work up to this.
4. Exhale through your mouth on a slow count of **six**.
5. Breathe normally for a minute so that you don't hyperventilate, then breathe deeply again on the count.

Do the preceding four or five times each session.

It is important that we, as family physicians, never fall into the monocausal trap. We owe it to our patients to examine as completely as possible before forming the diagnostic assumption upon which we will base our therapy. ■

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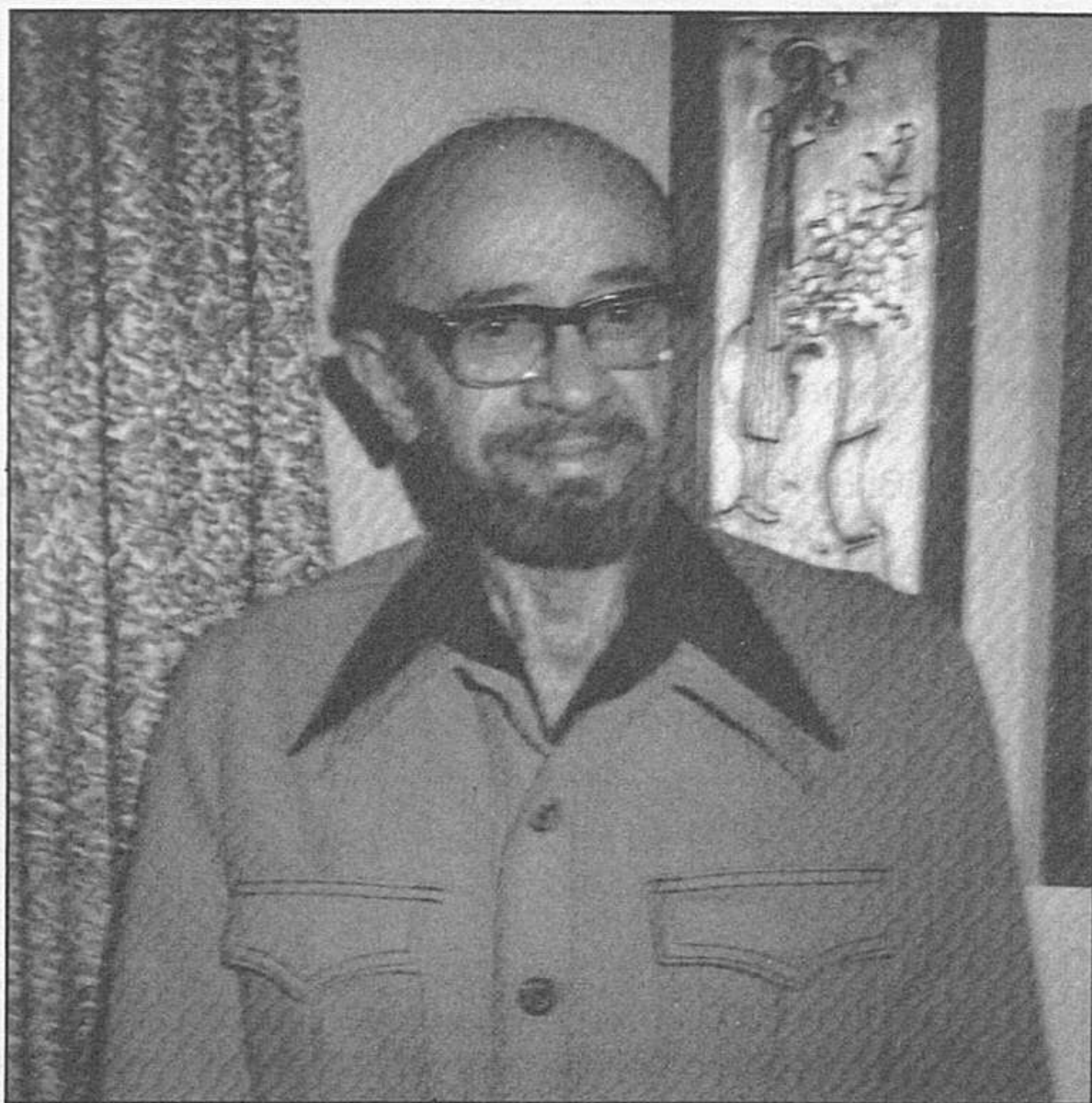
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MARCH, 1980

VOL. 2 NO. 3



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THE CHIROPRACTIC FAMILY PHYSICIAN is published bi-monthly by the Council on Diagnosis and Internal Disorders of the American Chiropractic Association, P.O. Box 1577, Glendale, CA 91206.

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PRESIDENT'S PAGE

Eldred A. Wilson, D.C., Council Pres.

Years do not denote age; it is ill health that denotes age. A person may be old at forty or young at eighty. It all depends upon the individual and the mode of living. A machine will wear out if not taken care of, or it will last almost indefinitely with care and replacement of parts when they become worn. The same reasoning will apply to the human machine; it must have care, consideration, and replacement of worn parts, that it may be kept fresh and vigorous to the last.

There is only one way, one gateway to rejuvenation, and that is exact compliance with natural law. If one wishes to escape the penalty of violation which is sickness, pain, disability and premature senility, a return to things natural is imperative.

The body as whole is composed of a given number of organic elements; each working part or organ is made up of certain elements dependent upon the function it is intended to perform. These elements are worn out and broken down, and must continuously be replaced if the organ is to maintain a high degree of efficiency. Furthermore, the parts must not be out of adjustment, and would not be out of adjustment were it not for violation of the law governing the part.

God made man and placed him here on this earth to fulfill a mission; made laws to govern him; endowed him with instinct with which to obey these laws; caused foods to grow containing the proper elements to sustain his body; did not decree that he should be sick, weak, or die prematurely. If man would but follow the simple laws laid down to govern him and obey those laws he could live out his span of life in good health. He could be hale, strong, fresh and vigorous to the end. Longevity would be his birthright. ■

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EDITORIAL "A Matter of Priorities"

by
Richard H. Tyler, D.C.

I sometimes wonder just how many of you reading this now finish reading the entire issue. I also wonder how many of you ever read what I write. Are these words I write just letters on an unobserved page? To be sure, letters arrive after just about every edition of CFP so we know that some of you do bother to read what we print. But, what about the vast numbers that just receive the magazine that we never hear from? What do you like and dislike? Are you the kind of physician who uses the material that's presented or is it just filed in the nearest wastebasket?

It is depressing, but I sometimes feel that most in the profession read and study as little as possible after they graduate. Or most will get to an occasional seminar on some technique that "is better than all the others" or to a success seminar to learn how to make bigger bucks faster, but how many I wonder take the graduate programs offered by our schools. I'm thinking now specifically of such courses as Orthopedics, X-Ray, and Diagnosis and Internal Disorders. Out of the thousands in the profession there is just a handful who seem to care enough to make the effort to learn something that might make them better physicians instead of just back popping businessmen.

I'm all for learning diverse adjusting techniques, for this is the "well" from which we draw our strength as a profession. And there is always a need to learn some better business concepts. But why isn't the same importance placed upon improving our basic knowledge to become a better all around physician. Few apparently really want to take the time. They're "too tired" or "too busy". But just let the next gimmick laden weekend seminar come along and off they go to be "revitalized" and "reborn" by the pitchmen.

Right now monthly classes are being formed to instruct chiropractic physicians in a course leading to the qualification and eventual diplomate status of the doctor as a "Chiropractic Internist." I cannot believe anything is more important than to attempt to make the proper diagnosis *before* we treat. The course is more important than any other graduate program whether it be Roentgenology or Orthopedics for they are but distillations of diagnosis and treatment within their *specialty*. What is needed is a broad base of knowledge *before* the distilling into specialties takes place. It's been a rather agonizing process however to get the council's educational program developed and accepted. This is good to a point because only the most sophisticated course is needed or desired. But I personally feel that there has been a good deal of foot dragging by some in the ACA, as if there was any doubt that a profession that wants to train primary physicians needs a course that would make them *better* ones.

After the dust clears and the courses that last for over two years have been established. I wonder just what the attendance will be. How many will be "too busy" to attend. Or how many will opt to go to some inane chiropractic carnival in Las Vegas instead of sitting in a classroom being instructed in the diagnosis of diseases of the respiratory system or in clinical cardiology or on the diagnosis of dermatologi-

B₆ — A NUTRIENT WORTH NOTING

by
David A. Rutolo, Jr., Ph.D.
and
Georgiana Hennessy, B.A.

Although vitamin B₆ was established as an essential nutrient in 1934, it has been only recently that many new uses for it have been discovered. This vitamin serves as a coenzyme in many important reactions throughout the body. These include the production of porphyrin, the iron containing portion of the hemoglobin molecule, the synthesis of certain neurotransmitters (i.e., serotonin), the conversion of tryptophan to niacin and nervous system regulation. B₆ is also involved in maintaining proper glandular function relating to water metabolism and it is also necessary for the conversion of glycogen to glucose for energy. Most importantly, vitamin B₆ is essential for proper utilization of protein necessary for numerous biochemical reactions of amino acid metabolism. It also plays a role in the proper absorption of amino acids from the gastrointestinal tract.

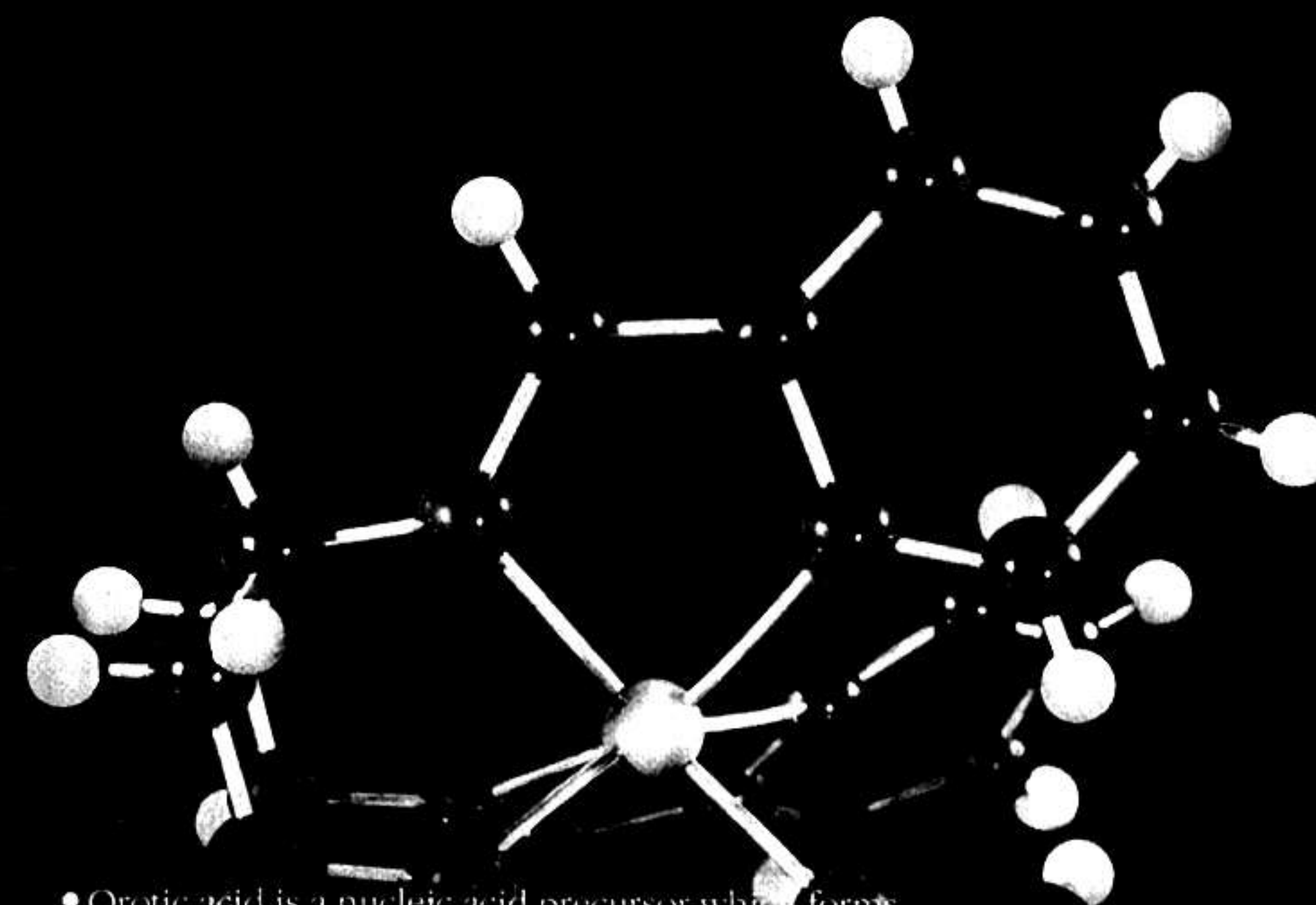
The exact human need for vitamin B₆ is still not known at this time and the problem is further complicated by the fact that certain people appear to be "B₆-dependent", requiring a great deal more of the vitamin than others. There is evidence that B₆ deficiency is quite common. The vitamin is found in most foods especially meats, cereals, lentils, yeast, egg yolk, and certain fruits and vegetables. However, improper cooking and processing of food destroys B₆. For example, frozen vegetables may lose 20% of their B₆ activity and milling of cereals can lead to losses of up to 90%.

The major symptoms of B₆ deficiency are weakness, irritability, insomnia, nervousness and difficulty in walking. Mental depression and lesions around the eyes, nose and mouth may also be observed. A deficiency of vitamin B₆ may lead to a certain type of anemia, and has been known to cause convulsive seizures and nervous irritability in infants. There are also several B₆-dependent diseases of inborn metabolism known such as cystathioninuria, familial xanthurenic aciduria, some pyridoxol-responsive anemias and certain infantile seizures.

The presence of a substance called kryptopyrrole, or mauve factor, found in the urine of certain types of schizophrenia patients and some normal persons causes the removal of vitamin B₆ from the body, and these persons may become extremely deficient. Use of oral contraceptives appears to greatly increase the need for vitamin B₆. Due to the intimate relationship of protein with B₆, individuals on high protein diets as well as pregnant women and persons undergoing rapid tissue formation (i.e., after injury, etc.) also have increased requirements for the vitamin. It also appears that oxalate kidney stones may be due to a vitamin B₆ deficiency with certain cases responsive to supplementation.

Vitamin B₆ is necessary for regulation of glandular functions involved with water metabolism. During B₆ deficiency, certain hormones are not released properly from the adrenal gland, leading to increased water retention. This seems to be the

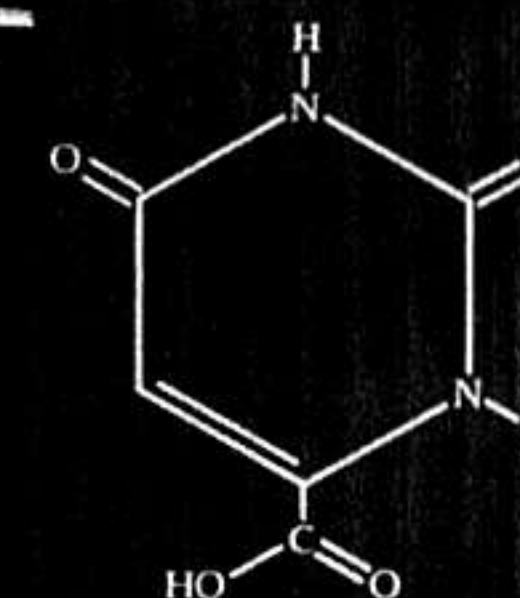
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Continued from page 6

situation in cases of edema of pregnancy, premenstrual edema, and edema associated with the taking of birth control pills. It is also thought that the symptoms of carpal tunnel syndrome, rheumatism, bursitis and menopausal arthritis may be due to increased water in the joints which creates pressure on nerves. Dr. John Ellis, M.D., one of the foremost researchers in the study of vitamin B₆ deficiency conditions, has had excellent results in treating these conditions with B₆ supplementation.

Another very exciting area of study is the role B₆ seems to play in the prevention of atherosclerosis. The amino acid methionine, in the course of its normal metabolism, produces a very toxic substance called homocysteine. In the presence of sufficient amounts of vitamin B₆, homocysteine is quickly converted to a nontoxic compound called cystathionine. In the absence of B₆, however, homocysteine builds up in the blood and leads to alterations in cells of the blood vessel walls and atherosclerosis. This hypothesis implies that high protein intake (supplying methionine) associated with a low B₆ intake, rather than cholesterol, might be the dietary link to atherosclerosis.

The significance of these findings is indicated in massive retrospective studies which have shown that women who have been taking birth control pills (which are known to decrease blood levels of vitamin B₆) for five or more years have a death rate due to cardiovascular disease *ten times* that of controls.

Vitamin B₆ is clearly a very important nutrient, and if the daily intake is even suspected to be too low due to improper eating or an increased requirement, supplementation is warranted. ■

BIBLIOGRAPHY

1. J.M. Ellis and J. Presley, *Vitamin B₆, The Doctor's Report*, Harper & Row, New York, 1977, p. 61.
2. *The Pharmacological Basis of Therapeutics*, ed., L.S. Goodman and A. Gilman, Macmillan, London, 1970, p. 1656.
3. E.R. Gruberg and S.A. Raymond, "Beyond Cholesterol", *Atlantic Monthly*, May, 1979, p. 59.
4. K. Guggenheim, "Studies on Water Metabolism of Pyridoxine and Pantothenic Acid Deficient Rats", *Endocrinology*, 55:156 (1954).
5. A. L. Latner, *Clinical Biochemistry*, W.B. Saunders Co., Philadelphia, 1975, p. 815.
6. C.C. Pfeiffer, *Mental and Elemental Nutrients*, Keats Publishing, Inc., New Canaan, Connecticut, 1975, p. 402.
7. *Nutritional Support of Medical Practice*, ed., H.A. Schneider, C.E. Anderson and D.B. Coursin, Hagerstown, Maryland, 1977, p. 36.
8. H.E. Saulberlich and J.E. Canham, "Vitamin B₆", in: *Modern Nutrition in Health and Disease*, ed. T.S. Goodhart and M.E. Shils, Lea & Febiger, Philadelphia, 1973, p. 210.
9. J.M. Willia, "A Review of Vitamin B₆", in: *A Physicians Handbook of Orthomolecular Medicine*, ed., R.J. Williams and D.K. Kalita, Pergamon Press, New York, 1977, p. 61.

"CARDIAC AUSCULTATION"

by
Richard H. Tyler, D.C.

Listening to the heart with the stethoscope is almost a farce. In the space of a relatively short time the examining physician is expected to listen to *and* evaluate the four valves of the heart and the cardiac rhythm. The subtle variances of auscultatory points, the differences in body types not to mention the differences in the auditory acuity of each doctor, make an accurate evaluation of what is heard almost impossible. Gross anomalies might be the only areas of diagnostic value.

We pride ourselves as being the type of physician who treat the cause not just the symptom. Because of this, it is extremely important that we extend our expertise into as many diagnostic areas as possible. That light whisper of a sound that we might overlook when listening to the heart could be the genesis of present problems or the precursor of a future major pathology.

The heart is a fascinating organ. A paragon of functional pragmatism. The right side of the heart handles the "old" or venous blood which contains erythrocytes loaded with carbon dioxide and thirsting for oxygen. The left side of the heart handles the freshly oxygenated blood that is ready to nourish the body. The upper two chambers receive and the lower two expel. Four valves aid in the proper conduction of the blood through the cardiac mechanism. The right atrium contains the "electrical" components that initiate the contraction and relaxation phases of the cardiac cycle. From the SA node to the AV node and then to the Bundle of His and from there to the left and right bundle branches and finally to the Purkinje fibers travel the impulses that initiate the rhythm we listen for. It is to the integrity of the valves and the cardiac rhythm that we must address our diagnostic efforts during auscultation.

The aortic valve is auscultated at the second intercostal space at the right sternal border. The pulmonary valve is best heard at the same level of the left sternal border while the tricuspid valve is heard around the xiphoid process of the sternum. The mitral valve can be heard at approximately the 5th intercostal space at the left mid clavicular line. The areas just mentioned are of course somewhat equivocal and the most profound sounds should be searched for.

The first sound or "lub" indicates the closure of the mitral and tricuspid valves. This first sound is further divided into an audible division which, if too pronounced, could indicate a pathological process. The second or "dub" sound represents the closure of the aortic and pulmonary valves. The splitting of the second sound can also be indicative of an abnormality. Often the splitting of these sounds can be elicited upon inspiration or expiration and this in itself can be quite diagnostic. The "blowing" or murmur sound that is heard indicates the degree of stenosis or regurgitation of each of the valves. A murmur on the second sound at the aortic and pulmonary areas and the first sound at the tricuspid and mitral indicates a regurgitation while a murmur on the second sound of the tricuspid and mitral valve areas and the first sound of the aortic and pulmonary would indicate a stenosis.

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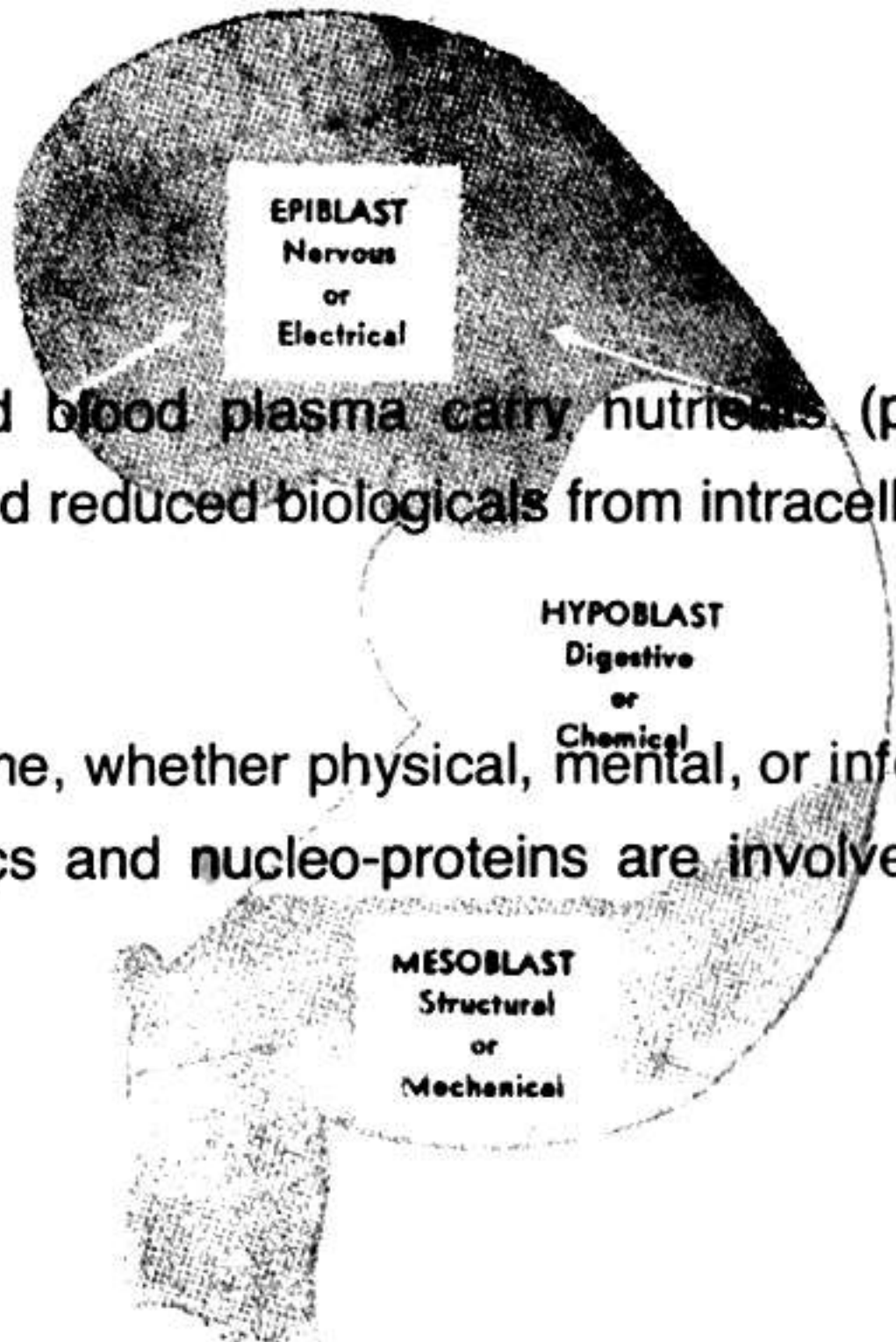
GLANDULAR AND ORGAN TISSUE SUPPLEMENTS

Glandular tissues are particularly involved with hormones, but both glandular and organ tissues are also involved with specialized nuclear proteins which are specific to each tissue. For this reason the subject is much broader than hormones although their importance is fully recognized and may be discussed at a later time. This present discussion takes in the entire scope of nutrition since each tissue is more receptive to the utilization of nuclear proteins which come from the same embryonic base of an animal as the particular tissue needs of a patient. When we speak of nuclear proteins we are referring to the highly specialized proteins which compose the cell nucleus. As this nutrient comes into the blood stream, it is now known that there is a unique affinity for cells of like tissue which need repair or nourishment of their nuclei.

Dorland defines nucleus as "the vital body in the protoplasm of a cell, the essential agent in growth, metabolism, reproduction and transmission of characteristics of a cell." These nuclear proteins are usually described as 'high-grade' proteins because they are presumed to contain all the complex ingredients required for normal cell functioning. When cells function at a level less than normal it is presumed that there is probably some deficiency in the level of quality or quantity of nuclear proteins of the cell. In such a condition it seems that a primary essential must be to provide like-nuclear proteins to these deficient functioning cells. This is the basic principle involved in the supplementation of organ and gland tissues which must be understood by physicians who contemplate utilization of this field of therapy. The use of these nutritional substances is in no way comparable to pharmacological therapeutics. With glandular and organ substances we are concerned with nourishment and repair of cells through providing their most easily assimilated vital needs . . . nuclear proteins from like tissues of suitable animal origin, prepared in ways which preserve all their most essential characteristics. Clinically we observe patients in early stages of cardiac malfunctions of various kinds respond dramatically to small daily intake of pills or capsules of beef heart. Similarly, the kidneys lagging in their normal functions respond to daily intake of kidney substance. One of the great universal hazards to life is degeneration of the vascular system. Supplemental use of substance derived from the arteries and veins of animals provides nuclear proteins which are specific to the nourishment and repair of weakening arteries and veins. The lymphatics are primary to the body's immunity systems and use of lymph, spleen and thymus tissues are dramatic in the strengthening of the body's ability to cope with stress, viral invasions and all forms of toxemia. There is probably no aspect of this type of therapy that is more gratifying and dependable. Most physicians who are experienced in their use would never give them up in their practices for any reason. If you have specific questions, write to the Chiropractic Family Physician or to the providers whose advertisements appear in our pages. ■

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BOOK REVIEW

"THE ECLECTIC APPROACH TO CHIROPRACTIC"

by
Fred Stoner, D.C.

Since I loved the title I had to get it. I felt that nothing that espouses an eclectic approach to the healing arts could be bad. I was right. At least I was partly right. The book is certainly eclectic if you're a straight. If you practice with broad strokes then the volume is more of a promise than a fulfillment. To be truly as eclectic as I would have liked it would have to include a summary of most of the orthodox and esoteric forms of adjustive therapy. It would have to have a full section on complete examination procedures and would have a section on physical therapy. Semantics is a tricky game. What is "eclectic" to one is restrictive to another.

On the plus side — and there are plenty of those — is that it is well written and illustrated and it does cover many subjects. The book contains thirteen chapters that range from Applied Kinesiology and Acu-Therapy to orthopedic and to neurological examinations. I particularly liked the chapter on laboratory procedures which was extensive and graphically presented. The chapter on nutrition was small but contained some useful and interesting information. But all of this seemed to be nothing more than wrapping paper for the core of the book — Applied Kinesiology. Dr. Stoner apparently is enraptured with reflex techniques and with AK in particular. The chapter on that subject is one of the most comprehensive sections of the book. In fact it might be one of the best produced texts on AK that I have yet to read. Photographs and drawings illustrate this section to make it worth the price alone.

The book, with a full index included, is 425 pages in a soft cover. When it was first offered the asking price was \$125.00. Then it dropped to \$90.00. I picked it up for its current college bookstore price of \$45.00. Certainly the latter price is more realistic as apparently someone learned. It's a funny thing however — just one bit of useful information gleaned from an expensive text can turn out to be priceless. I found this to be so when I read Dr. Stoner's book. It was well worth what I paid for it. In fact, if I had the money it would have been worth five times the asking price. But that's how I feel about books. They are timeless things that may guide and inspire those who read them. "The Eclectic Approach to Chiropractic" did guide and at times inspire. ■

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SYMPTOMS AND THEIR INTERPRETATION

“When a dozen years ago, I wrote the first edition of this book, I dimly perceived that there was a field of medical knowledge essential to progress which was left almost unexplored. It might seem absurd to say that the field of symptomatology was in this state, for has not the study of symptoms been prosecuted since the dawn of medicine? Nevertheless, the more I have gone into this subject the more evident has it become that symptoms have NOT been properly investigated, and even the methods by which the investigation should be pursued have not yet been understood.

“Though the value of symptoms has been recognized, yet the nature of their importance has not been clearly understood, and in consequence the manner in which they should be studied was not guided by a definite object or on sound principles. Disease is only made manifest to us by the symptoms it produces, but when a man falls ill the function of every organ of the body may be disturbed, and did we possess the means an infinitude of symptoms would be discovered. As it is, new methods are continually being devised for the detection of new symptoms, and medicine is breaking up into an ever-increasing number of sections. Men are devoting much time to special subjects and using the resources of other sciences in developing their specialty. In this way, an ever-increasing number of symptoms are being revealed. This kind of research seems justified by the belief that because a new fact is discovered knowledge is progressing.

“Whereas, the reverse is the case, for this kind of research only tends to defeat its object. In place of advancing knowledge, it actually hampers it by clouding over the methods and the objects of the science of medicine, by an ever-increasing mass of details. The progress of true knowledge is ever accompanied by a simplifying of the subject. This is because the laws of Nature are few in number. Details, with no understanding of the laws which govern their production, only lead to confusion. The discovery of the laws, on the other hand, tends to bring order out of chaos by classifying the details according to those laws which govern their production.”

The above could well be written by a present day chiropractor. By one who recognizes the fact that all symptoms are neurogenic reflex manifestations of disturbed function. Such is the considered opinion of many members of the Council on Diagnosis and Internal Disorders who wish to expand the diagnostic ability of chiropractic family physicians. This is our purpose and the reason for our classes; check with the chiropractic college nearest you.

The opening statement was made by the world renowned diagnostician Sir James Mackenzie, M.D., F.R.C.P., LL.D., F.R.S., F.R.C.P.E. (Hon.) at St. Andrews, Scotland in October, 1920. This remarkable clinician recognized the importance of the nervous system almost 60 years ago and developed an outstanding diagnostic method that is just now coming into its own.

SALUTE TO DR. ELDRED A. WILSON

Most readers of the Chiropractic Family Physician have enjoyed several issues of Dr. Wilson's tapes relating his interesting and very informative experiences serving a rural Missouri community as a typical chiropractic family physician. His competence, ingenuity and sensitivity has established a classic standard which is a tribute to chiropractic services to a grateful public. If you missed any of Dr. Wilson's chronicles you may want to get back issues out of your library and pursue some very interesting reading.

Dr. Wilson graduated from the Cleveland Chiropractic College in Kansas City in 1944 with degrees of D.C. and Ph.C. He was a member of the college faculty for two years and completed two years of post graduate studies at the American College of Naturopathic Medicine, earning an N.D. degree. Dr. Wilson was affiliated with the Kansas City Associated Medical Clinics for two years, as head of the Department of Chiropractic.

In 1963 Dr. Wilson settled in Slater, Missouri where he established a general family practice. He was active in community services as indicated by his acting as President of the Slater Lions Club for two terms and Secretary-Treasurer for 14 years. He received the 'Lion of the Year' award in 1970 and 'Secretary of the Year' award in 1975. He was elected to the Slater City Council for a three year term in 1971 and also served as Chairman for the Community Betterment Program of Slater and received a certificate of commendation for this from Governor Warren Hearns of Missouri. Dr. Wilson has been associated with Spears Chiropractic Hospital in Denver, Colorado as a member of the Field Research Council and Certificate from Spears Hospital as a Field Staff Member. Dr. Wilson is a member of ACA and the Missouri State Chiropractic Association.

Dr. Wilson's participation in community activities is significant and is witness to his high standing as a concerned and hard-working citizen. Dr. Wilson, you are one of Slater's citizen assets, and a notable asset to the chiropractic profession. ■

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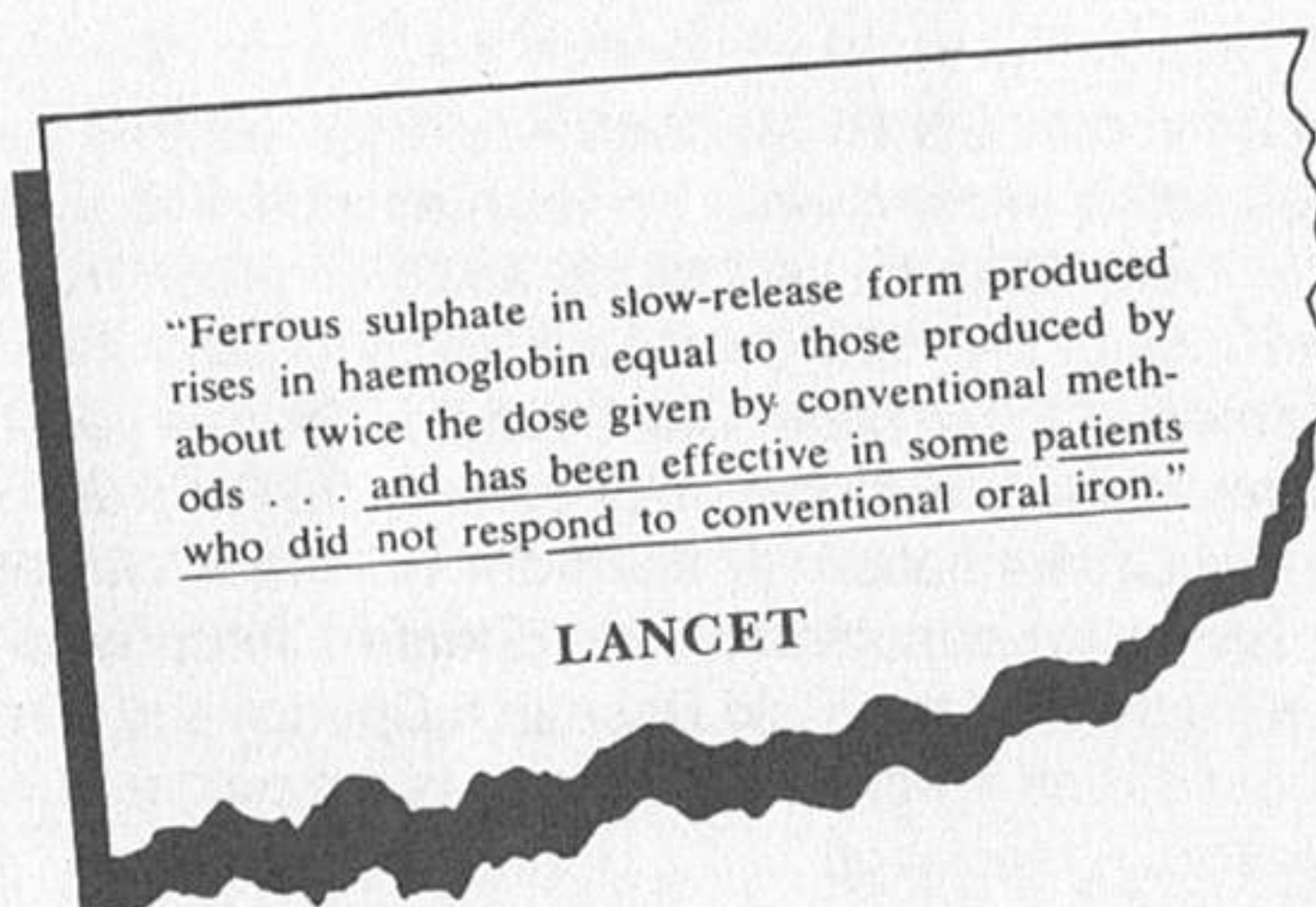
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TREATMENT AND CARE OF THE PROBLEM EAR

Ray H. Houchin, D.C.

EQUIPMENT NEEDED:

Otoscope
Ear Syringe
Ear Basin
Ear Tweezers
Cotton Balls and Cotton Tipped Applicators
Hand Towels(terry cloth, preferably gold colored for stain resistance to Vitaminerals #120 Solution).
Beauticians Shampoo Cape
Stainless Merthiolate Solution
Septisol Soap (or similar surgical scrub soap)
Eye Dropper, small Test Tube or Vial, small Dish or wide-mouth shallow plastic glass
Wax Dissolving Ear Oil (may obtain from General Biological, Francis L. Vore, Dist., P.O. Box 164, Arkansas City, Kans. 67005)
Vitaminerals #120 Astringent and Detergent Concentrate
Distilled Water

PATIENT PREPARATION FOR IMPACTED WAX

Give patient bottle of ear oil to be used as follows: 2 drops in each ear at bedtime and prior to arising. Let soak for 2-3 minutes in each ear before turning the head. This is done by the patient for at least two and preferably three days prior to irrigation.

THE IRRIGATION

Be very careful of water temperature. The ear is extremely sensitive to heat and cold. All solutions, water, etc., should be tested carefully to a temperature just slightly warm prior to using.

Drape patient with shampoo cape. Place a folded terry cloth towel (secured with a clip or clothespin) around the neck, over the cape to keep patient dry.

Pour a small amount, approximately one teaspoonful, of Septisol Soap in the ear basin and add barely warm water. If assistant is not available, ask patient to hold basin snugly against head to catch the water that will return. Fill ear syringe and gently insert LARGE tip into ear and apply firm, steady pressure to plunger for irrigation. Repeat irrigation at least four or five times. Inspect the ear with otoscope to observe if wax has been extracted, and to perhaps re-direct your flow of solution to allow it to penetrate a spot that will direct the flow behind the impacted wax.

Discard this solution and rinse in clear, warm water. REMEMBER TO WATCH THE TEMPERATURE CAREFULLY. Three or four syringings are usually sufficient to remove the solution. If wax is still present, rinse again.

Give patient a cotton tipped applicator and ask patient to dry inside the ear as far as they can reach without causing pain. This is very safe. Patients will not hurt themselves.

Have two droppers of merthiolate solution in a small test tube pre-warmed by standing tube in cup or glass of very warm water. After patient has dried inside ear, tilt head away from you and pour one dropper of merthiolate solution into ear, instructing patient to keep head tilted for approximately fifteen seconds. Hold a cotton ball to the ear and gently tilt head towards you at the end of the fifteen seconds to drain. Give patient a clean cotton tipped application and instruct to dry again.

Have pre-heated a bottle of ear oil (may be set in the same container with the tube of merthiolate for warming) after the final drying, one drop of oil is placed in each ear to lubricate.

On occasions, if the patient has not properly "oiled" the ears at home, it will be necessary to have them repeat their procedure before wax can be extracted. Be sure to stress to them the importance of using the oil as directed. It will save you time and aggravation.

We have used this method in our practice for fourteen years and have not had one incident of infection or complication as a result.

INFECTIONS OR FUNGUS OF EARS

Follow the above procedure of irrigating, omitting the drop of ear oil and substitute the following procedure:

A small cotton ball, carefully unrolled, makes an ideal ear wick. Use a thin strip, approximately six inches long, tapered to a point at one end by rolling between fingers and palms. In a small dish or shallow, wide-mouth plastic glass mix five drops of Vitaminerals #120 with one (1) teaspoonful of distilled water for each wick desired. This cannot be made up in advance. It must be mixed at the time of use. Place tapered end and approximately two-thirds of the wick in the #120 solution.

Using ear tweezers, pick up the tapered end of the wick at the very tip. DO NOT squeeze the #120 solution out of the wick. GENTLY insert the end of the ear tweezer containing the wick into the ear canal, do not apply pressure, but let glide along until resistance is met. WATCH PATIENT CLOSELY. THEIR EXPRESSION WILL TELL YOU WHEN YOU HAVE INSERTED DEEP ENOUGH. Withdraw the tweezer, leaving the tip of the wick intact inside the canal. Reach back on the wick very slightly and insert more wick inside the ear canal. Repeat this insertion until there is only a small portion of the wick left. This is left just outside the canal for removal. When wick is inserted, have patient lay head to opposite side and with a dropper, completely saturate the wick with #120 solution by pouring a few drops directly into the ear on the wick.

Advise patient to leave wick in ear for a period of 24 hours if possible. However, if pain or irritation occurs, they may remove in four hours with noticeable results. Occasionally a wick will be packed too tightly and can cause pain. Advise patient if this occurs to return to the office. Remove the wick and re-pack with less pressure.

When treating an infection, we use this treatment daily until symptoms subside, usually two or three days, then every other day until condition is clear.

The Vitaminerals #120 is a drying agent and will cause a dark rust appearance generally on wicks that are extracted. While treating every day, have patient leave

the wick in until they return. At this time simply take hold of the end of the wick outside the ear canal and slowly extract. After the acute phase, patient can remove this wick himself.

It is a good idea after the infection or fungus has cleared to re-wash the ear as outlined and use a drop of oil.

We have numerous patients whom we classify as "chronic waxers". They rapidly form masses of wax impactions and these should be routinely checked.

Our office uses the "tickle" or "suspense" file, rechecking these patients every three to six months, or every year, depending upon the patient need, to ascertain if this impaction is there. We irrigate the ears when needed and render a real service to this patient by preventing many infections and discomforts of the ear.

The entire procedure is completely safe, painless and very soothing to an irritated ear canal.

A FOOTNOTE FOR THE COMMON EAR ACHE

Instruct patient to use a large glass, fill about half full of boiling water. Add half teaspoon of Vicks Salve and while steaming, hold glass straight and have patient place ear over the top of the glass, sealing the vapor to enter ear. Be sure the glass is not too full so as to burn the ear with the boiling water. Have them hold this position for about one minute. In most instances this procedure will give immediate relief. Very valuable in relieving earaches associated with children. ■

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Continued from page 9

From the preceding it's obvious that the proper type of listening instrument is of utmost importance. A stethoscope should have a combination of chest pieces, a bell for low pitched sounds and a diaphragm for high pitched murmurs and sounds. The best tubing is made of plastic with a bore of at least 3/16 inch in diameter. It is also apparent that the best stethoscope in the world cannot accept all the subtle shadings of cardiac sounds and that with the often marked variances in auditory acuity of the doctor, a visual denominator would seem the most reliable method of analyzing what is heard. Phonocardiography is undoubtedly the most viable way to transcribe into a permanent record all the sounds, thus enabling the physician to more carefully and accurately develop a diagnosis.

Cardiac auscultation is important and care should be taken to be as accurate and perceptive as you can with whatever instrumentation you may use. Mid thoracic, cervical, chest and arm pains as well as dyspnea can all be part of a cardiac pathology. Don't treat anything until you're as certain as you can be just what it is you're treating. ■

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Continued from page 5

cal problems? All of the undergraduate study on the same subjects can never begin to duplicate the clinical application available through post graduate programs offered by our colleges.

It is my hope that all of you reading this will sit down and make a list of your professional priorities. If being a better physician is at the top of the list then taking the graduate program in Diagnosis and Internal Disorders is the most viable way to attain that goal. You can still be a great technician and you can still be the best businessman around — but that shouldn't stop you from becoming a good *physician*.

— Announcement — Supplemental Books Relating to the Bennett Teachings

So many inquiries are coming in for more information pertaining to Dr. Bennett's lectures on the 'Dynamics of Correction of Abnormal Function' that we have made arrangements to provide supplemental books in paper back as follows:

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ROENTGENOLOGICAL BRIEFS KLIPPEL-FEIL SYNDROME

Compiled by J. Eric Griffiths, D.C.

Diplomate, American Chiropractic Board of Roentgenology

A radiological definition of this disorder by Meschan states it is a synostosis of two or more cervical segments with varying degrees of partial fusion and malformation giving rise to associated hemivertebrae and irregularities in the laminae and spinous processes. Clinically, there is a triad of signs generally associated with this disorder: marked shortening of the neck, low posterior hairline, and severely restricted neck motion. Recent reports have shown patients with Klippel-Feil may be suffering from other less apparent more serious defects. In one report these "hidden" abnormalities were shown to occur as frequently as the well-known clinical triad which was found to occur in only 50% of reported cases.

As chiropractors, we are performing many routine cervical roentgenographic examinations and should be familiar with these "hidden" disorders and should avoid viewing Klippel-Feil "as just another interesting x-ray." In two reports it was found that unless three or more vertebrae were involved the usual clinical triad was likely not to be detected.

Fusion of the cervical vertebrae, the roentgenographic hallmark of Klippel-Feil, may occur as a simple synostosis of two bodies, congenital blocked vertebrae, or a massive fusion of several vertebrae. Flattening and widening of vertebral bodies as well as hemivertebrae and absent or hypoplastic intervertebral discs were common features. The radiographic findings may also be found in the upper thoracic spine. Males and females seem to be equally affected. Symptoms directly attributable to the cervical anomalies will develop in 65% of the time before the age of 30.

The most frequent orthopedic anomaly (60%) is scoliosis and kyphoscoliosis. Any evidence of fused vertebrae in a cervical roentgenographic study should be followed by a scoliosis study of the thoracolumbar spine. If the scoliosis is below 50 degrees, it should be managed and watched conservatively; however, if over 50%, the patient should have an orthopedic consultation.

Sprengel's deformity is associated with a reported incidence of 30% to 40%. This relationship is logical when one considers that at the third week of gestation, the scapula develops from mesoderm tissue at the level of the third or fourth cervical vertebrae. It descends to its thoracic position at approximately the eighth week, approximately the same time Klippel-Feil is thought to occur.

Renal abnormalities have been found to occur in as high as 35% of the cases with Klippel-Feil. These anomalies have included unilateral absence of a kidney, kidney hypoplasia, horseshoe kidneys, ectopic kidneys and hydronephrosis. Renal failure due to one of the above anomalies is well documented. It is interesting to note that the original case described by Klippel and Feil subsequently died from nephritis, not from the massive cervical fusion that attracted their attention. A comprehensive follow-up of the patient with Klippel-Feil should include a renal evaluation.

Continued on page 28

SOUNDNESS OF MIND AND BODY

by
Leonard D. Godwin, D.C.

Let's talk simply and non-technically and logically:

The human body, if not deformed by heredity or later crippling accident, is designed to be used and to be used best in certain non-injurious ways. If the body is fed and rested and exercised properly, it will remain in good tone and all of its parts will function at their maximum of efficiency. This is a solid definition of HEALTH, as far as it goes. Health, then, can be defined as the proper use and care of the body so that all of its component parts work as each was designed to do.

However, the human being is more than just a physical body: human beings have minds and in a complex and still only partially understood way express all degrees of emotion. And these thoughts and emotions are not independent of the body; in fact, they are influenced by the body in countless and not always obvious ways, and they also influence the body in various ways. So, the definition of health must, to be more complete, include the factors of thought and emotion.

Any thought or emotion that interrupts or alters or interferes with normal bodily functions is “unhealthy.” Psychologists, philosophers, and sages have long warned us against the kind of thoughts that can generate over-strong and uncontrolled emotions, for these kinds of emotions do influence the body’s proper functions and, if long-continued, produce either altered function or increased susceptibilities to diseases.

What kind of thoughts and emotions have ill effects upon the body's health? Well, the list is extremely long, but they all have one thing in common among them: they are all negative and thus destructive in some way. So, now our revised definition of *health* is thus more inclusive: the proper use and care of the body and the mind and the emotions so that all aspects of the human being function as one harmonious whole in its continuous efforts to adapt to its constantly changing environment.

We, as Doctors of Chiropractic, while we try to take into account all aspects of each human being whom we treat, our main concern is with the effects of the body's structure and how it influences the body's functioning. Now we understand that altered structure will sooner or later produce some kind of altered function in the organ affected. It stands to reason, for example, that a kidney which has slipped down in the abdominal cavity from its normal position (Nephroptosis) will not continue to function in precisely the same way as it did before the dropping occurred.

Now, a little appreciated fact in this story is exactly the reverse of the above, and that is simply that a change in function in an organ from its normal activity will likewise sooner or later produce some kind of alteration in structure. This is particularly obvious in bony structures. For example, as seen on x-ray films, an arm that has been in a cast following a broken bone (altered function, i.e., less than normal usage of that arm) will show a loss of calcium salts in the bone (structure). Incidentally, an immobilized part, such as an arm in a cast, will also show other structural

changes: the muscles will have decreased in size and strength, which implies that the arteries and veins to that arm are not carrying on their normal functions, the nerves will show slight and even moderate changes in function, and even the skin will look and feel differently than the other “used” skin of the body. In fact, it might be said that prolonged immobilization of any body tissue accelerates the degenerative changes associated with advanced old age decay and dying. Obviously the body is designed to be used and this usage facilitates continued good health. But what kind of usage? What happens when the body is used but used improperly?

Prolonged and habitual faulty body usage such as the great American postural slump, actually alters the shape of the bony parts of the spine. In other words, the **SHAPE OF AN ORGAN** will tend to change to conform to how it is used: poor use will result in poor shape. Now I've simplified the essential ideas here for the sake of brevity, but even in this skeleton outline and as general a statement as it is, the fundamental truth of the above cannot be logically or scientifically contradicted.

Excepting deforming injuries and a faulty inheritance, health and the simple job of being radiantly alive that goes along with it are at bottom the proper use of the mind (constructive) and the emotions (positive) and of the body (structure/function maintained within its designed limitations). No sane man would abuse a new automobile as some of us improperly use and non-use our bodies-minds-emotions. Did not the ancient Greeks promote a similar notion over 2000 years ago with their *mens sana in corpore sano* ("a sound mind in a sound body")? ■

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Hearing loss has been shown to occur in up to 30% of cases of Klippel-Feil. Because of the obvious serious social and academic handicaps associated with deafness, one should always give adequate attention to a child found to have blocked vertebrae to determine possible hearing defects.

Synkinesis referred to as mirror motions where there is involuntary paired movement of the hands and arms. That is, a patient is unable to move one hand without the other mirroring its activity. This condition which may occasionally occur with cerebral palsy or Parkinson's is very rare among the general population; whereas, it has been shown to occur up to 20% to 30% of cases with Klippel-Feil. This is thought to be due to a neurological anomaly as opposed to any direct relationship to spinal deformity. Fortunately, the condition does seem to improve with age.

Cardiovascular anomalies are reported to occur with greater frequency than the general population and should be considered with a complete work up of Klippel-Feil Syndrome.

The next blocked vertebra you detect on x-ray should stimulate your investigative curiosity into ruling out the possibilities of other "hidden" anomalies. ■

REFERENCES:

Hensiger, R.N., Lane, J.R., and MacEwen, G.D.: The Klippel-Feil Syndrome: A Constellation of Related Anomalies. *J. Bone-Joint Surgery*, 56A: 1246-1253, 1974.

Meschan: Analysis of Roentgen Signs, Volume I. W. B. Saunders, 1973, Philadelphia.

Rothman Simone: The Spine, Volume I. W. B. Saunders, Co., 1975, Philadelphia.

Dr. Nelson's Notebook Continued **A CASE OF ULTRA SONIC IRRITATION**

This phenomenon has not been recognized in the author's experience and it is related here that other chiropractic physicians may be made aware of it.

The patient is an eighteen month old male baby suffering from a medical rotation of the left foot and an abduction of the great toe of the same foot when walking; the left foot is one half size smaller than the right. Examination was unremarkable except that spasticity was found in the surface reflex area for the internal rectal sphincter. It was felt that this vasomotor center could well be causing the muscular and circulatory irritability responsible for the symptoms.

The internal rectal sphincter had been treated assiduously but there had been no apparent response in the symptoms and the area being treated showed no change. This was most unusual particularly in a child where rapid improvement is the rule.

A relative of the family came to visit and upon stepping into the house complained of piercing and irritating noise which neither of the parents had heard. It was soon established the noise originated from the ultrasonic generator of the burglar alarm system. This generator was left on all the time and only the receiver turned on and off

as required. The guest and the baby could hear the sound but the parents could not.

Physiology claims the human ear can detect 30 to 20,000 cycles per second. Ultrasonic burglar alarms develop 25,000 to 50,000 cycles, presumably beyond human hearing. That this is not so is evidenced by the guest and by a specialist in these alarms who agreed that many of his employees are able to hear the sound and that he himself will leave a department store that has one on because if he remains in the irritating environment for fifteen minutes he will get an upset stomach.

The parents of the baby now turn the generator off when they enter the house and the patient's internal rectal sphincter is responding well to treatment. In fact, the improvement was dramatic. ■

EDITORIAL DIRECTIONS

It is the purpose of the Chiropractic Family Physician to awaken the profession to the possibilities of providing all essential general health services needed in our society which cannot be obtained in the medical industry. We specify 'general' because we exclude such peripheral services as dentistry, optometry, etc.

The second purpose which is corollary to the first is to stimulate the profession to an awareness of the need for broad post graduate clinical education in sufficient depth to properly qualify ourselves to competently provide services as chiropractic family physicians in both diagnosis and therapeutics. If we make waves at times it is because we are intent upon achieving these objectives . . . we are dedicated to progress in this direction so some waves are likely to result. It is only when we drift that we make no waves. Some people consider any state other than drifting inflammatory and dangerous. The Chiropractic Family Physician has no intention of being an inflammatory media even though we have at times permitted expression of some positions which were sufficiently jarring to shake up some of us out of our complacency. We do not intend to pursue those expressions as a policy as that would get in the way of our pursuit of our stated purposes.

We do not believe it is possible for new graduates of our professional colleges to be fully qualified to properly fulfill all the responsibilities of chiropractic family physicians. We strongly encourage residencies as well as post graduate clinical courses as spelled out in the Syllabus approved by the Council on Diagnosis and Internal Disorders. We encourage the new graduates especially to take the courses provided in the accredited chiropractic colleges concurrently with their first two or three years of practice. The undergraduate courses of necessity contain so much academic material it is impossible to also include the breadth and depth of clinical experience to meet the high standards expected by today's society. We believe it is possible for chiropractic family physicians to achieve a public image as exceptionally competent diagnosticians. When this is achieved no one can question our position as primary health care providers. Our commitment is to this goal, all else is irrelevant. ■

Ralph J. Martin, D.C.

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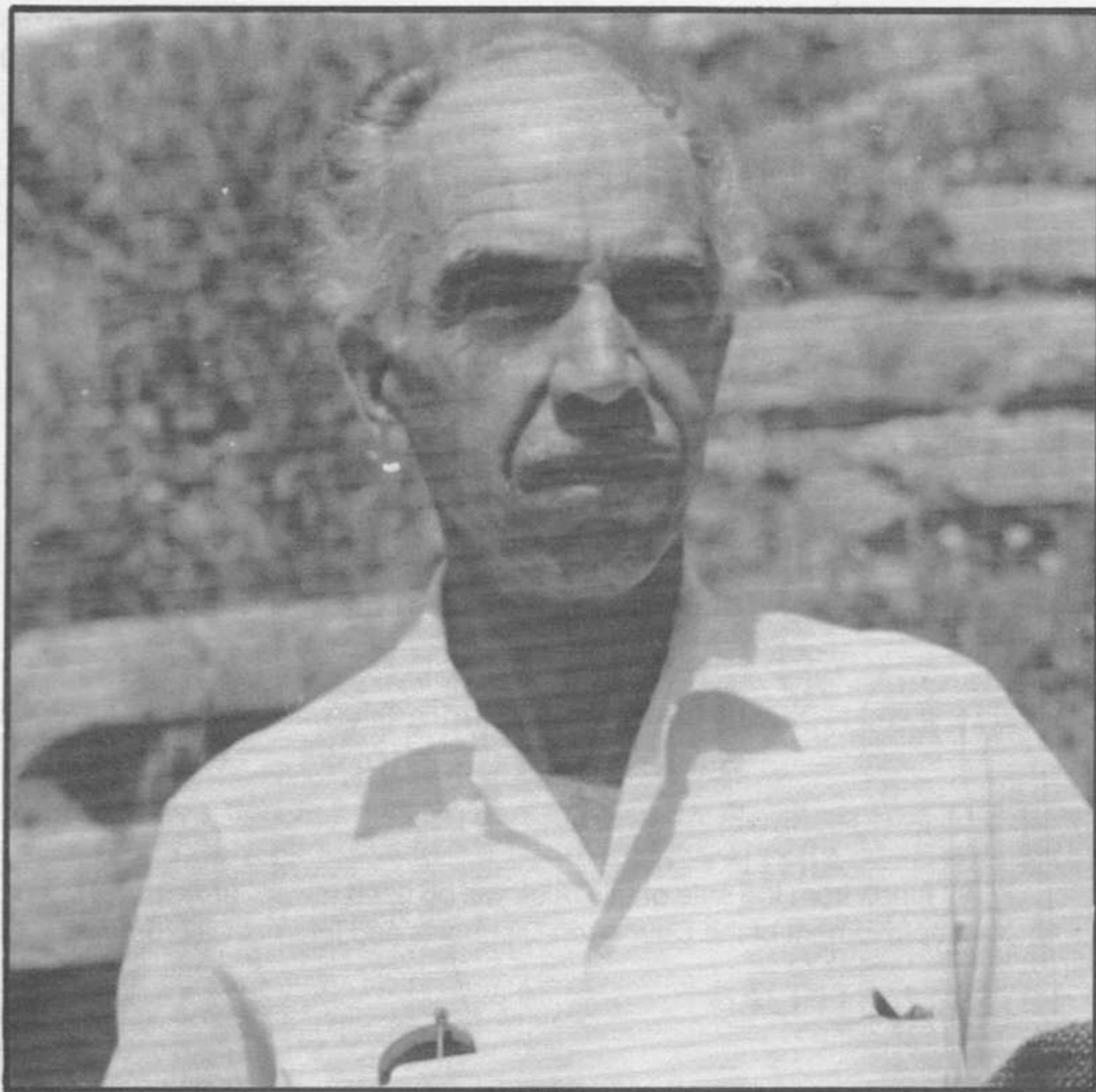
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MAY, 1980

VOL. 2 NO. 4



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THE CHIROPRACTIC FAMILY PHYSICIAN is published bi-monthly by the Council on Diagnosis and Internal Disorders of the American Chiropractic Association, P.O. Box 1577, Glendale, CA 91206.

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Circulation: Not less than 11,000.

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PRESIDENT'S PAGE

E.A. Wilson, D.C., Council President

The Council on Diagnosis and Internal Disorders will soon be ushering out the old year and heralding in the new year. This will be the last issue of the Chiropractic Family Physician before the ACA convention at Denver, Colorado.

Your officers sincerely hope you have enjoyed the Chiropractic Family Physician throughout the year. We hope you have increased your clinical expertise in expanding and improving your role as a family physician this past year.

Such articles as submitted by Dr. Ralph Martin on Breast Examination, as well as such clinical articles as those prepared by Dr. Richard Tyler will continue to appear in the Family Physician. I feel certain that the very valuable information given by Dr. William Nelson on the Perennial Low Back has helped all of us in caring for such conditions. The Treatment and Care of the Problem Ear by Dr. Ray H. Houchin and appearing in the March issue of the Family Physician is a splendid article and exemplifies the role of the chiropractic physician as the family doctor.

Our status with the Internal Revenue Service as well as the Postal Service has been put on proper course by the untiring efforts of our editor, Dr. Ralph Martin and our Executive Director, Dr. William Nelson.

Membership increase has been very gratifying and shows the sincere desire of chiropractic physicians to increase their service to their patients.

Yes, I believe we have had a good year, a productive and satisfying year. It has been an exciting and memorable year serving as your president. Thank you. ☐

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EDITORIAL

"The Other Side of the Coin"

by

Richard H. Tyler, D.C.

I'm sure that its relatively safe to say that there are probably more predictors of doom within the ranks of the chiropractic profession than there are in any of the other healing arts. Perhaps it's some kind of intellectual masochism or a professional "bondage" fetish. Whatever the reason the fact seems to be that we have always had a rather strident group of Cassandras among us. Before you entered school the picture painted was always one of great promise. Once the doors of the college had closed behind you you were regaled with horror stories about our imminent professional demise.

What made me think of this was a letter that a colleague recently received from his state association which rather graphically told with word and illustration what a small band of straights were planning to limit us to through legislation. If passed, the bill would leave absolutely nothing but the adjustment. So what's new? I can't remember when some form of restrictive legislation hasn't been pending in some part of the country. This doesn't mean that we shouldn't be ready to defeat such stupidity but let's not panic every time some straight rattles the chains. Yes — we do suffer occasional setbacks. But these are rare compared to all the positive steps we make every day. Just read some of the news in the journals. I can often count almost 10 good items to one bad.

All of this is due to the hard work of a dedicated few who quietly inform the profession and then do battle on our behalf. They deserve our support financially and morally. It just seems sad that some apparently feel that it's necessary to use scare tactics to gain that support.

Chiropractic is the fastest growing of all the healing arts. Our schools are now packed with young well-educated men and women. I have the feeling, in talking with some of them, that they are not afraid of anything the future holds but instead are resolute in their determination that the profession they are about to enter will not only survive but will prosper.

So let's stop all the wailing and do the thing that will *insure* the perpetuation of the art and science of chiropractic — maintain and *increase* our educational standards. Knowledge is both a sword and a shield when used in a just cause.

Take graduate courses. Constantly feed your mind with the wisdom of others whom you respect. And when you have done all of that — begin again. No legislator in the world can deny a man whose desires are based upon knowledge. ☐

TRIBUTE TO Stanley Melville Innes, D.C.

Dr. Innes received basic training at the Palmer School of Chiropractic in Davenport, Iowa. He served on the school's instructional staff before initiating private practice in San Jose, California, a practice that continued for 52 years until his untimely death on April 7, 1974. For two successive terms Dr. Innes served as president of the California Chiropractic Association after having been intimately involved in its organization.

He was among the first to study under Terrence J. Bennett, D.C. Precision in diagnosis and development of skill in reflex therapy became the major fields of research, study and application Dr. Innes pursued throughout his long and challenging career. His patients came from wide geographical areas, many families to the fourth generation. His appreciation of the value of reflex therapy was such that he has provided the means from his estate to make possible the publication of the Bennett Lectures in the hard-back book "Dynamics of Correction of Abnormal Function". The lectures therein are the last and only lectures Dr. Bennett ever permitted to be taped. It is income from sales of this book that underwrites the publication of The Chiropractic Family Physician which is now well launched into its second year of publication.

Dr. Innes was an avid skier for many years, a traveler to far and remote areas and familiar places on six continents. He was a vital, interesting, beloved man who was forever grateful to Dr. Terrence J. Bennett whose teachings added such enrichment to his successful practice of chiropractic. □

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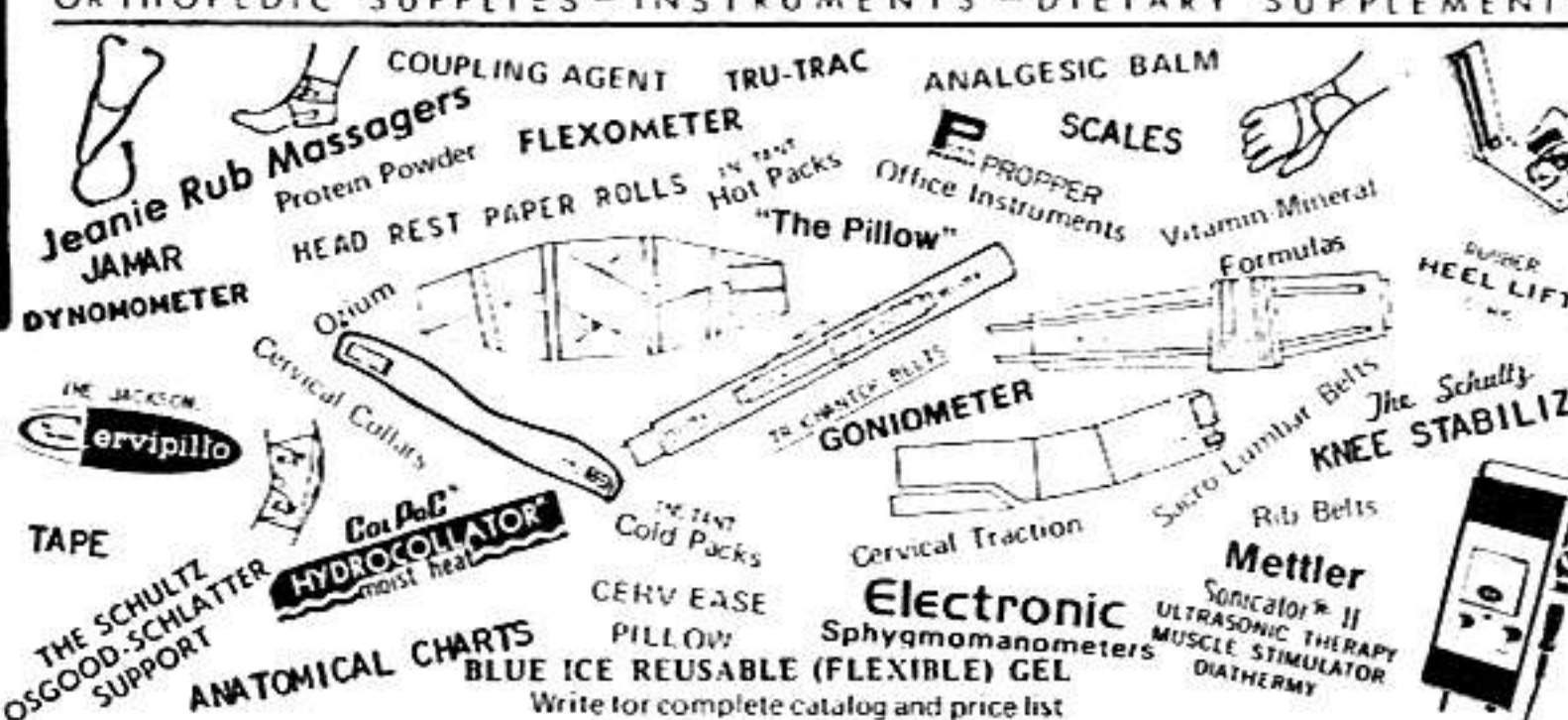


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MITRAL VALVE PROLAPSE: THE BARLOW SYNDROME

by
Jeffrey W. Greene, B.A., B.S., N.D., D.C.

In recent years a syndrome has been described in patients with clinical findings of a nonejection click and a late systolic murmur ascribed to the mitral valve. Barlow demonstrated that the late systolic murmur behaved like the murmur of mitral regurgitation and showed that it was associated with protrusion of the mitral valve leaflets into the left atrium during the middle third of systole. These findings, coupled with a distinctive electrocardiographic pattern, now constitute the syndrome that appropriately bears Barlow's name. Anatomic features have been documented both at the time of surgery and at postmortem examination. These features include voluminous, scalloped leaflets of the mitral valve as well as myxomatous degeneration of the valve substance without any inflammatory changes. Barlow's syndrome is often referred to as the "floppy mitral valve syndrome."

Incidence. As the Barlow syndrome is a newly emerging entity, there is much yet to be learned about its natural history. It has a striking predilection for women, and since it also has a characteristic echo-cardiographic pattern, there is opportunity to study *Clinical Profile*. The syndrome occurs most frequently in young or middle-aged women who present with a variety of symptoms that include chest pain, lightheadedness, dyspnea, fatigue, and palpitations. Chest pain has been found in 60 percent of patients with symptoms, and it has been attributed to ischemia of the posterior papillary muscle due to excessive stretching of the chordae tendineae that are attached to the billowing mitral leaflet.

Auscultation. This reveals a snapping extra sound in middle to late systole. The extra sound is heard loudest at the apex or just inside the apex, and it is considered to be the auscultatory hallmark of the Barlow syndrome. In some patients the sound has a scratchy quality or makes multiple clicks that may create the erroneous impression of a friction rub. The click is often followed by a late systolic murmur, but not invariably so. In other patients, only a pansystolic murmur is audible. It is important to realize that the midsystolic click may not be present in the supine position, but it may emerge as the patient assumes the left lateral decubitus or upright position. The click occurs earlier during inspiration, in the straining phase of the Valsalva maneuver, and following inhalation of amyl nitrite.

Electrocardiographic Findings. The ECG in the Barlow syndrome often shows inversion of the T waves in leads II, III and aVF, with or without minimal ST depression. Similar changes may appear in the left precordial leads as well. Ventricular irritability is considered a frequent accompaniment of this syndrome and is estimated to occur in 25 percent of the cases. Often an exercise stress test is required to unmask the ventricular irritability. No associated abnormalities of the coronary arteries have been found to account for the electrocardiographic changes.

Continued on page 20

RESEARCH — CLINICAL INVESTIGATION — STATISTICS — THE MEDIA

There are too many individuals in the chiropractic profession who are making costly and often misguided decisions about research who really do not understand what it is. Webster's 7th New Collegiate dictionary states regarding research: "to investigate thoroughly — careful or diligent search — studious inquiry or examination — investigation or examination aimed at the discovery and interpretation of facts, revision of accepted theories or laws in the light of new facts, or practical application of such facts or of such new or revised theories or laws." This is an over-simplification in terms of what researchers today consider to be the parameters and scope of their profession. There is general agreement of professionals in the field of science that unless research employs very specifically defined controls in addition to the factors being considered, it is not research but investigation with general rather than specific value.

There is frequent reference to 'medical research' among chiropractic speakers and writers. This is a myth, for certainly it would be hard to find any evidence of research conducted by the American Medical Association. The research they propagandize and lay claim to is done by the great pharmaceutical companies and not many of those engaged in the drug research are actually M.D.s. Investigating the published reports shows that most of these are signed by Ph.D.s and M.A.s.

Today we are hearing too often of rushed and falsified reports to avoid loss of time and loss of a product by competitors getting onto the market first. We also hear of deaths and horrors of injuries to people who have suffered from inadequately tested drugs which have been rushed onto the market. Aside from research in drugs which utilizes animals in order to adhere to the strict principles of controls and other requirements there is research in physiology being done in the universities, not by M.D.s but by Ph.D.s and their associate M.A.s and others. Most of this is being done with animals with attempts to apply the findings to human beings, which too often gets off into highly speculative conclusions.

An attempt was and is being made to research the physiology of the spine at Colorado University. The fact that Dr. Suh is an Ph.D. in Engineering has made it too difficult to get physiological information from the project and when this became apparent the ACA withdrew its support from the project.

In the matter of utilizing human beings in research projects instead of animals, a whole new field of human values is being opened up which is highly controversial; and hideous and disastrous consequences have resulted, which when made known have made research using people as subjects a highly objectionable enterprise. Witness recent disclosure of the army testing secretly the effects on humans who were not informed that they were subjects of research in certain devastating drugs. There are too many hazards to the concept of the sacredness of human life to tolerate using people as subjects of drugs and other hazardous research. This fact makes research in most fields of health and disease virtually impossible to qualify for the true parameters of research. This leaves then only two legitimate possibilities for

productive exploration of information relative to health of human beings . . . clinical investigation and statistics. It is an interesting fact that the late Dr. Henry G. Higley, M.A. D.C., who headed the ACA Department of Research and Statistics from 1964 to his death in 1969, recognized that accepted technical research in human health and disease was virtually impossible, *leaving only clinical investigation and statistics* as practical fields of exploration. His reports in these fields are a monument to his energy, insight and dedication to significant achievement of a respected place in science for the chiropractic profession.

Clinical investigation has been attempted in our chiropractic colleges with several projects and very limited success. The efforts to implement clinical investigation in college clinics has lacked continuity due to the unstable tenure of clinic directors and of clinicians. Thus the college clinics have been very lame vehicles for producing substantive results. Doctors in the field are even less informed regarding the necessary procedures for recording and reporting their efforts in clinical investigation so such efforts have been dismally disappointing. If and when we as a profession arrive at a point that we can produce scientifically acceptable reports, this will be where the media comes into the picture. Clinical investigative and statistical reports however carefully and properly prepared have very little value unless they reach the media and are published. Published distribution opens up the subject to other investigators, whether friendly or critical and thereby stimulates possibilities for further unfolding of information on a given subject. Unpublished reports have value only to those who compile them.

The current pressure by the ACA upon the Councils to produce some form of 'research' in their respective disciplines such as Diagnosis and Internal Disorders has no real value other than political except that possibly some individuals in the Councils who have some insight into the parameters of clinical investigation and statistics may be motivated to set up some guidelines for requirements that would apply to the disciplines of their council. It is possible that this form of study may be useful and productive. Certainly it would represent the one and only step that would be feasible as a beginning in such a vast field. ☐

Ralph J. Martin, D.C.

NEW CLASSES IN PROGRESS

Classes in diagnosis and internal disorders are now in progress and available to those wishing to extend their services. The physician must be skilled in diagnosis and a practical course is here now. Designed to make the chiropractor confident and competent they are currently being taught in St. Paul and Los Angeles. The schedule may be found elsewhere in this publication. Certificates will be awarded but, of greater importance, you will know that you have been trained with the best — a most satisfying feeling. Inquire at once of the college nearest you.

A short course in the Bennett approach to functional diagnosis will start May 16-17 in Ames, Iowa. Contact the postgraduate department of Northwestern College of Chiropractic.

DR. NELSON'S NOTEBOOK

LET'S TELL IT LIKE IT IS

It is about time for those of us who consider this profession to be a boon to mankind to get with it. The light should be taken from under the basket. We have matured over the years and should be ready to stand up and be counted.

The members of the Council on Diagnosis and Internal Disorders have made their commitment. They KNOW what they're standing for, recognition as primary care physicians. Without exceeding our individual state laws, the practice of chiropractic comfortably allows one to be a physician. Being a primary provider does not require treating all conditions; it does require knowing when to refer.

When to refer is a sticky one. Two components immediately present themselves. The first is diagnosis and the second follows naturally, competence. Diagnosis is the first consideration in the making of a physician. Without diagnosis one is a technician or, worse, a threat to society. Competence is an individual matter and is determined by adequacy of schooling and amount of postgraduate study plus the ability to learn. Happily, the Council on Diagnosis and Internal Disorders offers a remarkable solution to the above dilemma. The solution is to be found in our internist classes which can be made available to those seeking to be recognized as physicians.

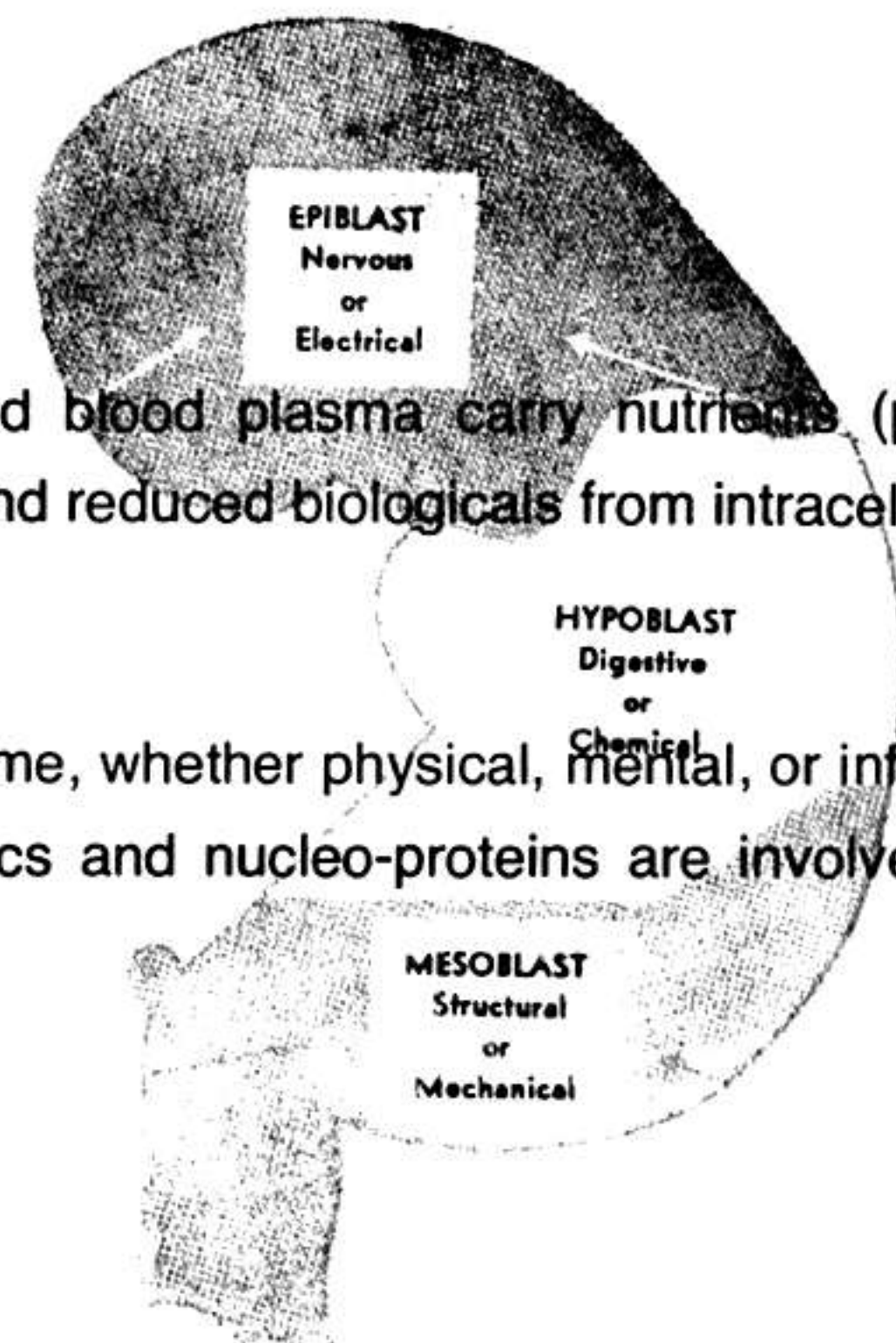
Too many chiropractors reduce their status as physicians voluntarily. They become intimidated and fail to tell it like it is. True, our government claims we're only technicians but this can and will be changed, if we persist. This temporary and limited area of our practice is no reason to extend the same thinking into other areas. But we do, consciously or unconsciously.

If the majority of us deliberately limit our diagnoses to simple musculoskeletal problems, we handicap our professional growth. The reason, of course, is the ease of insurance payment. Ultimately, the truth will out and we'll be branded as hypocrites who proclaim our propensity and ability to our patients but knuckle under to third party carriers.

Try being honest and see what happens. Some time ago a female was hemorrhaging so badly an allopath wanted an immediate hysterectomy. The uterus is intact and not hemorrhaging but the carrier refused to pay for five chiropractic treatments with a diagnosis of uterine hemorrhage. The state association officers put their tails between their legs and slunk away. A case of vaginitis was questioned but paid. A recent case of ischemic heart disease was questioned but it is anticipated will be paid. These occurrences are far too common and must not be allowed to continue.

Nothing good and permanent was ever built by faint-hearted men. Change doesn't come easily but it is coming and it is up to each of us to lend a hand. Ignoring our philosophy in order to accommodate the allopaths is not only demeaning but not conducive to the best interests of chiropractic. We think differently, we practice differently and we get results. Let's stop fooling around and tell it like it is. ☐

THE LYMPHATIC SYSTEM . . . IMPORTANT LINK OF INTRACELLULAR METABOLISM



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THE IMPORTANCE OF PERIPHERAL VASCULAR DIAGNOSIS

Robert J. Wiehe, D.C.

Lower Lumbar Disc involvement with resulting L4-L5 nerve root entrapment and thus sciatic nerve syndrome constitutes one of the most frequently seen problems by you, the Chiropractic Physician.

One of the chief conditions accompanying this problem is neurovascular stenosis — constriction of the large arteries in the leg due to the nerve inflammation. Herein lies a potential problem that can lead to permanent damage to the patient and invite legal hazards for the doctor.

The problem is that organic vascular disease, such as a thrombosis of the femoral artery, can cause the exact same symptoms as that of sciatic neuritis.

Thus the doctor can be misled into attributing these symptoms to a diagnosis of sciatic neuritis when, in fact, the diagnosis is femoral thrombosis.

Obviously the latter condition should be referred to a Vascular Surgeon. Failure to do so would definitely constitute negligence on the part of the Chiropractic Physician.

Thus, it is mandatory that we conduct a proper, adequate, vascular examination on every patient with lower extremity subjective or objective signs and symptoms — regardless of the obvious evidence of neuropathy in the lumbar region.

Vascular Examination of the Lower Extremity

Objective — To determine the presence of any vascular obstruction or restriction of blood flow and to differentially diagnose such vascular conditions.

Procedure — Different measurements of blood flow, both quantitative and qualitative should be conducted.

1. BLOOD PRESSURE COMPARISONS

Unilateral/Vertical and Bilateral/Horizontal studies are made.

Blood Pressure (systolic only) should be taken at the ankles — above and below the knee — and at the upper thighs. Doppler ultrasound, blood pressure cuff pick up, or photo cell plethysmography can be used.

Indications —

Unilateral/Vertical — Blood Pressure should be lowest at the ankle — normally it will raise as you go up the leg. A jump of over 15mm from any one section to the next is indicative of a stenosis between those two areas.

Bi-Lateral/Horizontal — Next compare the blood pressures at corresponding levels in the two legs — a difference of over 15mm is also indicative of stenosis.

Continued on page 14



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2. PULSE VOLUME RECORDING/PLETHYSMOGRAPHY

Plethysmography is a term that describes any of several methods of measuring and recording the volume of blood flow through a vessel. Most often used to diagnose and differentiate vascular disease of the lower extremity. It is also employed in the differential diagnosis of Thoracic Outlet Syndrome. Two common types of plethysmograph are used today — Photo Electric and Blood Pressure Cuff Pick Up.

Photo-Electric Plethysmography — Lower Extremity

Procedure — It is important that these examinations be run in the phelbo-static level state i.e. the patient supine and level.

The patient should also be warm and comfortable.

Step #1 — Screening

Photoelectric pick up units are placed on each digit of the lower extremity — a qualitative graph is made of each 1st digit followed by quantitative graphs of the remaining digits.

At this point the physician has sufficient information to correlate (the graphs and the blood pressure comparisons) to determine if a vascular problem exists.

If findings suggest a vascular stenosis further tests should follow to verify and differentiate the problem. A reactive hyperemia test is indicated.

Step #2 — Reactive Hyperemia Testing

Purpose — To induce vaso dilation in the suspected extremity in order to differentiate between a neurovascular spasm and an organic disease of the vessel.

Blood volume is measured before and after the vaso dilation by means of the photo cell or pressure cuff recording device. A marked increase in PVR (pulse volume record) following the dilation procedure indicates the problem to be neurovascular.

No change in the PVR suggests an organic disease of the artery.

Procedure — There are several methods of vaso dilation that can be employed in order to run the differential test of vascular stenosis.

Elevating the body heat of the limb.

Ingestion of alcohol.

Post Tibial Nerve Block.

Reactive hyperemia by artery block via pressure cuff.

Reactive Hyperemia by Pressure Cuff

Either a pressure cuff and PVR pick up or a plain blood pressure cuff can be used. In the latter, place the blood pressure cuff around the ankle and inflate to a point above the systolic pressure. Lock from 5 to 15 minutes. Upon release of the cuff vasodilating substances will be released and simultaneously PVR graphs are taken. A comparison to graphs taken prior to the Reactive Hyperemia test will define the problem and distinguish between neurovascular stenosis and organic vascular disease.

Other areas of blood vascular disease can also cause similar problems of diagnosis and also need to be examined.

Thoracic Outlet Syndrome and Cervical and Cerebral Vascular disease can mimic neuropathies frequently treated by the Chiropractic Physician. In the case of Thoracic Outlet Syndrome photocell plethysmograph can be useful in diagnosis.

Doppler Ultrasound is an effective and important method of separating Intra and Extra cranial symptoms of cervical nerve root pressure syndrome from organic vascular diseases such as carotid thrombosis and cranial vascular problems.

These non-invasive diagnostic procedures are much safer — more convenient — and far less expensive than angiogram screening tests and should be employed by every prudent chiropractic physician as standard operating procedure. ☐

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THE PATIENTS YOU SEE TODAY

IRON A PROBLEM?

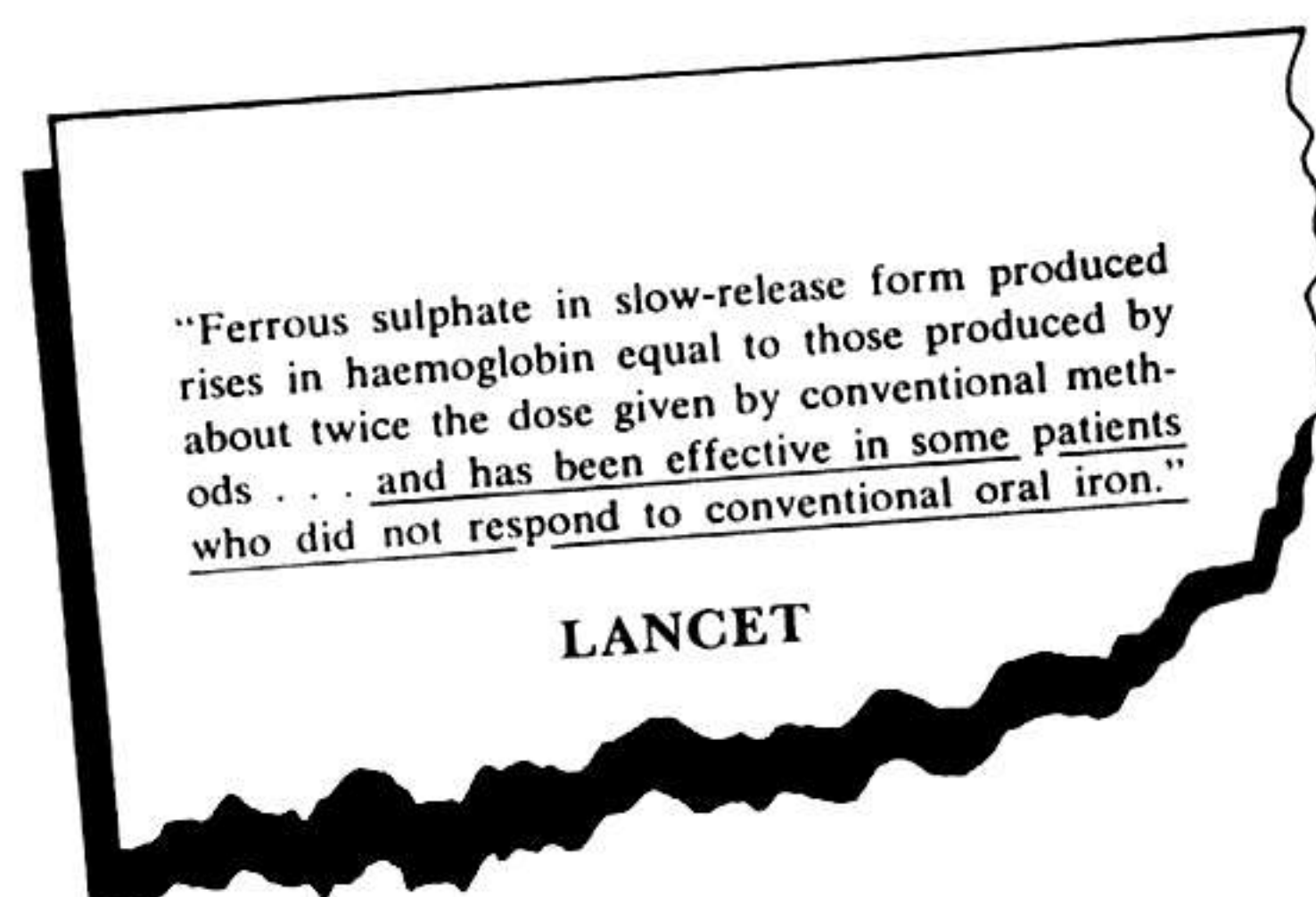
Easy fatigability, depression, anorexia. Later smooth tongue, brittle skin (cracking at corners of mouth), brittle nails, ridged fingernails — then a meaningful drop in small, pale RBC's!

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"THE EYES REALLY DO HAVE IT"

by

Richard H. Tyler, D.C.

The eyes have always held man in fascination. Beauty from the shape to the color have been poeticized through history. Being "windows" to the mind great powers have also been ascribed to them. Leaving the romantic and the esoteric behind, the eyes form a valuable diagnostic tool for the physician to use to discern pathology even in systems far removed from the examined area.

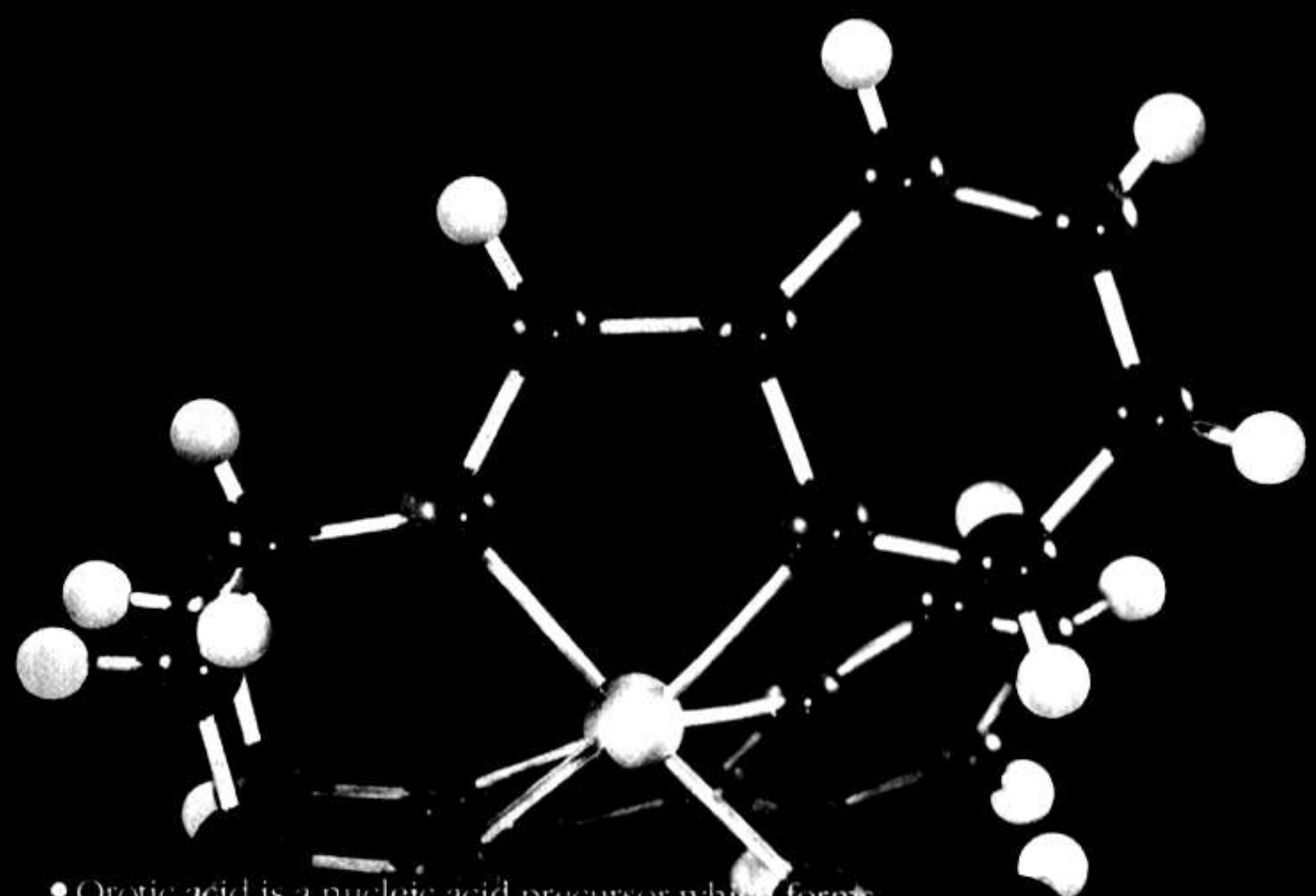
Often you hear the remark that the doctor just doesn't have time to examine the eyes — "After all that's why they have ophthalmologists." As a chiropractic physician it is almost incumbent upon us to examine the eyes. Just think of all the visual problems caused by structural aberrations — that alone should be the price of examination. Properly trained in the actual examination procedure, the doctor can make a rather comprehensive evaluation in a relatively short time.

Look carefully at the eyes for their overall appearance. Observe the socket, Is the eye sunken as in tissue wasting from a serious yet not clinically observable pathology or can you see exophthalmia which would indicate a possible thyrotoxicosis, xanthomatosis, hyperpituitarism, cavernous sinus thrombosis or one of the histiocytoses? Observe the lids for infections with palpebral edema and erythema as a sign. Do the lids flutter indicating emotional stress? Are xanthelasma plaques observable around the eyes indicating a probable hypercholesteremia? Is the sclera injected and inflamed or is it yellowed with icterus indicating a hepatic problem? Is there an arcus senilis around the iris of a patient under 40? If so this could be an indication of hyperlipidemia. Observe the cornea. Is it opaque as seen with cataracts or in Interstitial Keratitis?

Check the movements of the eye to indicate a possible cranial nerve involvement. Is there nystagmus in the primary position indicating a possible multiple sclerosis or a brain tumor? Examine the field of vision. Are there areas of peripheral diminution which might also indicate a tumor?

With the ophthalmoscope observe the fundus for such pathologies as papilledema seen in increased intracranial pressure or disc cupping as observed in glaucoma. Visualize the vascular supply for indications of arteriolar sclerosis polycythemia vera, leukemia, diabetes, congenital heart disease, rheumatic fever, hepatitis, syphilis, multiple myeloma and sickle cell disease. Spots on the retina may indicate hypertension or lupus erythematosis.

It may have taken you a minute or so to read the preceding. Add another few minutes and you could do the actual examination. After a short while you'll be able to see what pathology might be present simply because you'll get used to observing with specific diagnostic concepts in mind. The more often you include an eye examination in your physical the easier and faster it will become. No physician worth his salt should have the excuse that he doesn't have time to examine his patients thoroughly. If he does he may be in the wrong profession. ☐

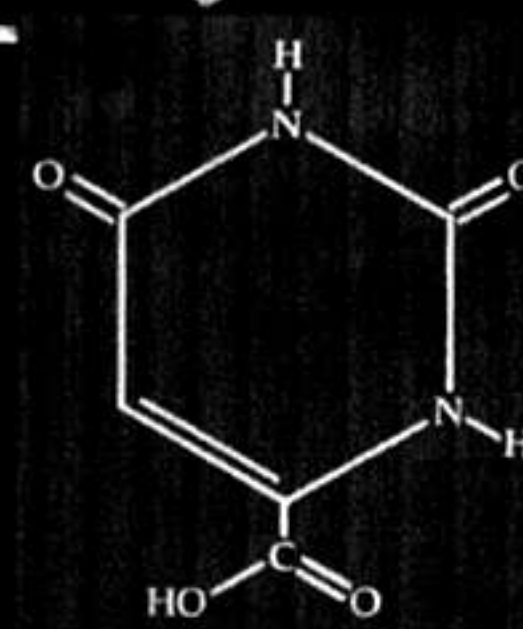


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"An Important Moment in Chiropractic History"

Richard H. Tyler, D.C.



The phone rang in the office of Ronald Lawrence, M.D. not long ago. It was the governor of California calling. "Dr. Lawrence, said Governor Brown," I'm going to ask a possibly difficult thing of you." There was a silence as Dr. Lawrence wondered what was to come next. "I would like to appoint you as the first member of the California State Board of Chiropractic Examiners. I know," he continued, "that there is a marked measure of resistance on the part of the medical community for any type of professional cooperation with chiropractic so an association of this nature could place you in an awkward position professionally. I feel however that cooperation of this kind is important and in the best interests of the public welfare." "I couldn't agree with you more," replied Dr. Lawrence, "I've been working with chiropractic doctors and teaching in their schools for almost 25 years. I consider such an appointment an honor." With this short conversation the appointment was consummated and the first member of the medical profession was now sitting on the chiropractic state board. This followed through with Governor Brown's perceptive and progressive health care concepts. Governor Brown may be one of our profession's greatest friends. Prior to the appointment of Dr. Lawrence, a number of chiropractors had been appointed to medical quality control boards throughout the state. Governor Brown is a fearless exponent of the welfare of the citizens of his state and is to be admired for his courage.

In most cases Dr. Lawrence's appointment to the board will probably be greeted with little more than a smile and a nod of approval but knowing Ron Lawrence as I have over the years makes it necessary for me to add enough to make those smiles become cheers for we have indeed been blessed by this appointment.

Dr. Lawrence is as unique as the man who appointed him. He is not just someone with an "M.D." tagged after his name. He is a highly respected member of the medical profession. A man of profound education and greatly honored by his peers. To list all of the interesting facts about Dr. Lawrence would take great time and space. To list a few — he holds a diplomate status on the national boards Electroencephalography, Psychiatry and Family Practice and is board eligible in Neurology. He is on the graduate faculty of the Los Angeles College of Chiropractic and on the faculty of the U.C.L.A. School of Medicine. He holds membership in the AMA, the International Academy of Preventive Medicine, the American Academy of Family Practice, the North American Academy of Manipulative Medicine and the American Association for the Advancement of Science and is a founding member of the International Association for the Study of Pain, the American Holistic Medical Association and the American Medical EEG Association. He holds fellowships in the Royal Society of Health, the American Geriatrics Society and the American College of Angiology. His interest in sports has led to an award from the United Nations and he is on the UNESCO Council on Sports Medicine. He is also a consultant to the U.S. Olympic Committee. An avid jogger, Dr. Lawrence has run in a number of marathons

and is the founder and president of the American Medical Joggers Association. His great variety of professional interests is exemplified by the fact that he is the president of the American Academy of Acupuncture Medicine and is the vice president of the International College of Hypnosis. Not content with all the preceding Dr. Lawrence's interest in research has led him to develop a form of acupuncture treatment known as "Osteopuncture."

We have therefore the good fortune of having on the California State Board of Chiropractic Examiners a man of great experience, integrity, knowledge and courage. A profession always needs the leadership to match its goals if they are to be achieved. In Dr. Ronald Lawrence we have a man who will support our continued progress to those goals. ☐

Continued from page 7

X-ray. This demonstrates no distinct features; however, the left cineventriculogram obtained at cardiac catheterization is diagnostic of the Barlow syndrome. It shows a billowing posterior and oftentimes anterior leaflet protruding into the left atrium during systole.

Echocardiogram. This has proved helpful in diagnosing the Barlow syndrome by demonstrating abnormal waveforms of the mitral valve echo in systole. There is separation of the posterior leaflet in systole in most cases. In addition, there is usually exaggerated excursion of the anterior mitral leaflet in diastole.

Complications. While ruptured chordae tendineae have been found in association with myxomatous degeneration of mitral valve leaflets, this is probably rare in the Barlow syndrome. The most disturbing feature is the occurrence of palpitations, and in certain instances, marked ventricular irritability. Originally it was thought that sudden death might be more common in patients with this syndrome, but as larger population studies are being reported, this has not become statistically significant. Infective endocarditis is a known risk and a recognized complication.

Treatment. Only in rare instances is the degree of associated mitral regurgitation severe enough in the Barlow syndrome to warrant mitral valve replacement. Medical therapy is directed toward control of bothersome arrhythmias. Propranolol therapy has been suggested to reduce the tension on stretched chordae tendineae, and this beta-adrenergic blocking agent is occasionally effective in reducing the frequency of arrhythmias as well. Prophylaxis against subacute bacterial endocarditis is recommended for all patients.

REFERENCES

- Eckberg, D.L., Gault, J.R., Bouchard, R.L., Karlner, J.S., and Ross, J., Jr. Mechanics of left ventricular contraction in chronic severe mitral regurgitation. *Circulation* 47:1252, 1973.
- Feigenbaum, H. Clinical application of echocardiography. *Progr. Cardiovasc. Dis.* 14:531, 1972.
- Jeresaty, R.M. Mitral valve prolapse — click syndrome. *Progr. Cardiovasc. Dis.* 15:623, 1973.
- Perloff, J.K., and Harvey, W.P. Auscultatory and phonocardiographic manifestations of pure mitral regurgitation. *Progr. Cardiovasc. Dis.* 5:172, 1962.
- Rappaport, E. natural History of aortic and mitral valve disease. *Am. J. Cardiol.* 35:221, 1975.
- Ryan, T.J. Mitral Valve Disease. In H.J. Levine (ed.), *Clinical Cardiovascular Physiology*. New York: Grune & Stratton, 1976. P. 523.
- Scheuer, J. Ventricular dysfunction associated with valvular heart disease. *Am. J. Cardiol.* 30:445, 1972. ☐

LETTERS TO THE EDITOR

Dear Sir:

Enclosed is \$20.00 for "A New Clinical Approach to the Correction of Abnormal Function" Bonnet, and "Clinical Manual" Papa.

Thank you. I found Dynamics of Correction of Abnormal Function interesting and useful.

Thank you again.

Sincerely,
Dr. Peter P. Mach

Dear Dr. Martin:

Enclosed, \$10.00. Please send a copy of: "A New Clinical Approach to the Correction of Abnormal Function" by Terrence Bennett.

Thank you. I think it's a great book, should be used in all the Chiropractic colleges.

Sincerely yours,
Ernestine Stowell, D.C.

Dear Dr. Martin:

I can't help myself, but I must respond to the editorializing in the Family Physician.

I enjoyed Dr. Tylers comments on osteopathy. They succumbed to materia medica 50 years ago. They were manipulating during the 1918 flu epidemic. A virulent flu, yet most people survived. They saw secondary bacterial infection and the debilitation of irreversible pathology.

I also, enjoy the comments directed toward the so-called musculo-skeletal practitioners. Usually astute differential diagnosticians, responsible, aware of malpractice. Not a locked in group, at all.

The journal is very informative. A little less stridency and the expanding of political science, which supports the nebulous, might be in order.

Knowing that we have our share, please continue to reform the fanatics who are racing and bring them home.

Yours truly,
Russell A. Heieth, D.C.

Dear Dr. Martin:

I have received my copy of Dr. Bennett's book of lectures and am reading it with great interest.

I am currently in my last year at New York Chiropractic College and am looking forward to utilizing the information and techniques set forth in your books on my own patients.

Thank you.

Sincerely,
Michael J. Cindrich

Continued on page 24

RESPONSE TO ARTICLE BY PETER MARTIN, D.C. WHICH EXPRESSED A CRITICISM OF THE AZEOTROPIC METHOD OF PROCESSING RAW GLANDS

Dr. Martin does not state the source of his information making it difficult to respond directly. But assuming his opinions are based on something read somewhere, we are submitting our rebuttal on his toxicity assertion.

To our knowledge, any discussion of solvent toxicity has always concerned the amount *inhaled*. It is important to note that any *oral* ingestion of tablets containing a residue would be minute compared to the amount that would be inhaled (and absorbed).

Heppel & Associates carried out a number of studies with mice and dealing with exposure to Ethylene Dichloride including a study on orally ingested EDC (Heppel, et al, J.L. Pharm. Exptl. Therap. 84, 53, (1945). On the basis of the mice studies of *oral* ingestion, a human could take approximately 260 pounds of food at *one time* containing 300 parts per million without ill effects.

We refer now to a study conducted by Professor C. Maltoni in Europe. There is belief that the Maltoni study is the most meaningful and thorough toxicological research conducted on EDC thus far, and that the results of this study are supportive of the current OSHA standard. Professor Maltoni considers the results to date as "almost conclusive" and states that "EDC has failed to show specific carcinogenic potential." When you consider that the azeotropic processing method has the advantages of removing fats and toxins while leaving raw tissue enzymes intact, it is a process so delicate that naturally occurring Vitamin C is retained, and that the solvent has been used for several decades in food processing, it seems unwarranted to switch to other processes which may leave obnoxious fat and pesticides in the glands.

Regarding the ability of azeotropic processing to remove toxins and pesticides, the following is contained in a W.A.R.F. Report.

PESTICIDE RESIDUES IN SALMON BEFORE AND AFTER AZEOTROPIC PROCESSING (From W.A.R.F. Report)

PESTICIDES (PARTS PER MILLION DRY WEIGHT)

	DDE	DDT	Dieldrin	Est. PCB
Air-Dried Salmon	23.8	8.00	0.36	37.50
Axeotropically Processed Salmon	0.20	0.09	0.005	0.32

Copies of the Heppel toxicity studies and the Maltoni report are available from Professional Service Dept., Nutri-Dyne Products Corp., 5705 Howard Street, Niles, Illinois 60048. ☐

Dr. Jack Schechter

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PESTICIDE RESIDUES IN SALMON BEFORE AND AFTER AZEOTROPIC PROCESSING (From W.A.R.F. Report)

	PESTICIDES (PARTS PER MILLION DRY WEIGHT)			
	DDE	DDT	Dieldrin	Est. PCB
AIR-DRIED SALMON	23.8	8.00	0.36	37.50
AZEOTROPICALLY PROCESSED SALMON	0.20	0.09	<0.005	0.32

Dr. Jeffrey Bland refers to the fat as "The obnoxious portion of meat" because the toxins accumulate in the fat.

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AZEOTROPIC means . . .

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AZEOTROPIC means . . .

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Remember that fat is the lodging place of
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AZEOTROPIC means . . .

High Vitamin and Mineral content.

AZEOTROPIC means . . .

*A process so delicate, that naturally occur-
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LETTERS (Continued)

Dear Sirs:

As a profession we have long assailed our medical colleagues on two points:

- a. The abuse (and at times the use) of pharmaceuticals.
- b. Not treating the "cause" of disease as we propose to do.

I think that it may be worth our cause as a profession to ponder these two points and reflect on how they currently apply.

Firstly, on the abuse of drugs. It is certain that no health professional would defend this practice. I think for this discussion we should broaden the term drug to include all therapeutic procedures. Our objection has not been primarily directed at the use of drugs, but at the abuse. So should our anger be directed at the abuse of all therapeutic armamentariae, and that includes manipulation.

We cannot, should not, and it is immoral for us to continually treat patients beyond the point where they have reached maximal medical improvement or have become asymptomatic. I think that once patients attain that level of response they should be so advised and told to report back if they have a recurrence or, in the case of certain degenerative neurological disorders, to report back every couple of months, depending on clinical need.

The idea of adjusting a patient every time he comes to the office, or doing some "other thing" to him, makes us as guilty as those we accuse.

Part of the problem is that we lack finite clinical criteria that are generally acceptable as to definite indications for manipulation in a specific patient. We have relied too heavily on the patient's subjective report in the past. I propose that we develop such universally acceptable (if not defensible) criteria and moderate the subjectivity.

Many will defend the present practice stating that adjustments are preventative and non-injurious.

I disagree. In my years of practice I have been unable to determine that periodic spinal manipulation has been preventing anything except possibly a lean bank account. Manipulation is not benign and thus not to be dispensed without clinical justification.

I feel these tenets of "prevention" or "maintenance" care are purely practice-building concepts.

Secondly, the concept of treating the cause: The concept is healthy as long as we refrain from the monocausal dogma of disease. At times we may feel that we are the originators of the concept of "finding the cause". . . . No . . . we can only take credit for restricting its definition. Determining the cause of disease is fundamental to all health professionals. It being axiomatic that to treat an illness one must understand its mechanism of production.

In the past, and presently, we have been taught in certain clinical situations as to whether in doubt — manipulate. That is, of course, after you have ruled out many other aetiologies. I say no. What happened to our "cause" dogma? Again let's devise criteria and we will many times avoid the vagaries of when or when not to adjust.

In those cases where one has been unable to reach a clinical diagnosis, but has "ruled out" everything, we have had as one defense, "Well, we do not know everything." Let us stick with the state of the art as it is and not "hide." If we do not know, then find out.

In my own experience, many of those cases that have gone undiagnosed were because the psychological factors had been overlooked or not accepted by the patient. We have all had those patients who have been everywhere and "nobody knows what is wrong with me," and too often we have also not formulated a definite diagnosis but treated the patient anyway — and often the patient responded to the manipulative therapy — but for the wrong reason.

In other words, the "cause" frequently is psychological, we manipulate, which does nothing for the basic emotional or psychological factors — so did we treat the cause. And this is also where manipulation per se is then open to ridicule — for we claim miraculous cures and apply the cure to the "wrong" therapeutic procedure.

Sincerely,

Willem J. Kruger, Jr, D.C.

Reprinted from ACA Journal, Dec. 1979

— Announcement — Supplemental Books Relating to the Bennett Teachings

So many inquiries are coming in for more information pertaining to Dr. Bennett's lectures on the 'Dynamics of Correction of Abnormal Function' that we have made arrangements to provide supplemental books in paper back as follows:

"A New Clinical Approach to the Correction of Abnormal Function" (1960)

By Terrence J. Bennett

\$15.00

This is a well organized presentation of basic principles.

"Clinical Manual"

Notes by Alice Papa, D.C.

\$10.00

Complete with Index and numerous Charts.

"Visceral Innervation"

By Raymond H. Houser, D.C.

\$5.00

A standard textbook with charts and explanations of spinal innervation to all visceral structures.

Send your check with order to:

Ralph J. Martin, D.C.

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Sierra Madre, CA 91024

"LISTENING WITH OUR EYES"

by
Richard H. Tyler, D.C.

The old saying that we sometimes cannot see the forest for the trees may too often apply to the giving of a physical examination. Many times the most obvious or observable element is overlooked in favor of the esoteric.

Everytime we look at a patient we see the skin but how often do we **look** at it. Before us is a segment of the body that can tell a wondrous story. The skin covers the entire body — and serves to protect the underlying tissues from infection, injury and dehydration. It also acts to control body temperature through conduction and the emission of moisture.

The integument is divided into three primary layers: (1) the epidermis, (2) the dermis and (3) the subcutaneous tissue. The epidermis is composed of two layers. The most superficial is known as the stratum corneum and consists of several layers of dead cells. Just below that is the Stratum Mucosum which is living avascular tissue which takes its nourishment from the underlying layers. The cells of this layer contain the pigment melanin. Concentrations of this type of pigmentation can be diagnostic of melanoma. Beneath the epidermis is the dermal layer which is considered the true skin. This is further divided into the papillary and reticular layers and contain blood vessels, hair follicles, arrectores pilorum muscles and sebaceous glands. The subcutaneous layer contains fat cells and the bodies of the sweat glands. This relatively thin tissue that we call the skin obviously contains a great deal and does a great deal — it should therefore be able to tell us quite a story.

Continuing the observation of your patient, such things as the shape of the skin can tell you something. An enlargement of the cranial vault in the elderly may be indication of Padget's disease. In the young it could tell you that the child might be experiencing an abnormal intracranial pressure or a nutritional deficiency. Is the head of the patient tilted as in torticollis? If the head nods while each heart beat this could be De Mussets sign indicating an aortic insufficiency. Is there a resting tremor as seen in Parkinson's disease?

The simple observation of a patient walking into your office can be quite definitive. Does the patient walk with the feet wide apart for balance as is seen in a cerebellar lesion? A spastic or scissors gait with the leg swung in an arc may be observed in hemiplegia while the foot slapping or steppage type may tell you that the patient has syphilis. Short festinating steps are seen in Parkinson's disease.

What about the patient's overall body type? Is he fat, thin or athletic. An obese trunk with wide hips, genu valgum, small hands and feet and micro genitalia could be Froelich's syndrome seen mostly in men, or does the patient have a round face and a pad of fat around the posterior cervical region and have a rather obese trunk with general hypertrichosis? It could mean Cushing's syndrome seen mostly in women.

A bronze like mask seen around the eyes of pregnant women is known as chloasma, or what about the facial mask seen in lupus erythematosus? If a patient is generally erythematous this would be a good indication of hypertension. If, on the other hand, the patient appears cyanotic it could mean a pulmonary involvement or if the hands particularly are bluish-white the patient could have Reynaud's phenomenon. The yellowing of the skin could mean an hepatic problem, bronzing of tissues might indicate a chronic adrenal insufficiency as exhibited in Addison's disease.

Continued on page 29

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The Mysterious Soma

Harold Heintz Payne, D.C., F.I.C.C.

Over the millennia that man has occupied this minute speck of dust in the universe, we call the planet earth, he has gradually increased his intellectualism. This, in turn, has led to the development of numerous and greatly varied cultures and civilizations.

Nor did they necessarily occur at the same time in history, or at one place only, but seemingly at widely scattered geographic areas. Neither has the process of their progression been at the same rate, or even a continuous one upward. Rather, it appears, they have been characterized and accompanied by many interruptions.

Each — with possible and exceptional outstanding instances — has made definite advancements. And each in its turn, has crumbled into the dust from whence it arose, only to be eternally forgotten. Or perhaps has left some as yet unexplainable remnants that has led to the blurred legends and myths of prehistory, or known to us as ancient history.

The tragedy of this has been that with their demise they took with them most, if not all of the knowledge that they had learned, a loss the world could ill afford to lose.

It appears that each of the great civilizations fell as the result of some devastating, physical catastrophe, over-affluence and self-reliance on self, and/or a gradual disbelief in a Supreme Being or Gods.

Due to man's inborn nature to survive after each fall, into an indescribable state of debauchery and decay, he has gradually and frantically again groped from the depths of the abyss in which he found himself, hopefully seeking for a better and higher goal. Perhaps he knew that there had been something much better in the far-distant past, that now existed only as a faint glimmer in his subconscious mind, not knowing that the Creator's foreordained plan in spite of man's recognition or ignorance of such would be executed in due time.

After each resurgence, man has advanced ever so slowly but eventually to a pinnacle of height unexcelled previously in some special endeavor.

However, in the fields of science and technology his progress in recent decades has been unparalleled, unprecedented and unsurpassed in the memory or knowledge of modern man. But seemingly at the expense of social, political and spiritual achievements.

These phenomena apparently have been repeated over and over again.

The unwritten events of the far distant past, we refer to as prehistory, those that we have some knowledge of we call ancient and medieval history respectively. Only that which happened yesterday and today can rightly be called modern history in this fast moving world.

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In our present state of sophistication, man has become so highly specialized, literally overspecialization, that a single individual can barely keep up with his own specialty, let alone comprehend in any degree of depth the overall knowledge of his particular discipline. Unfortunately this has often led to misinformation or even complete ignorance of many other aspects of learning.

However, many scholars today recognize the shortcomings of the above and are now beginning to approach most of the complicated problems that constantly confront them from the holistic point of view. This has already and will continue to "payoff", yielding information relative to many of the mysteries of the past, present and possibly predictable future. This generally just could not and did not occur when individuals worked more or less alone and tried to ferret out the mysteries of the past by themselves.

Let one example suffice.

No one has known for centuries upon centuries what the mysterious Soma plant was. It was even lost to the ancients. They knew, as have we, from the various ancient writings that the plant was related to an ancient cult named after it. That it was highly venerated and considered a sacrificial plant, that was considered sacred, intoxicating, narcotic and hallucinogenic as was well attested to by *Rigveda*, the earliest of the *Samhitas* (literally — Book/s of Knowledge).

Most of these writings, some 1000 hymns or so, are addressed to various deities, but their central theme seems directed toward the Soma cult. These Sacred Hymns are written in Vedic, a most ancient form of Sanskrit, and were supposedly well known approximately c. 1500-1200 B.C. by the early Aryans that apparently came to India from Irania.

Due to extensive and intensive interdisciplinary research, the mystery that so long surrounded the sacred Soma plant of prehistory and the ancients, has now been identified beyond any shadow of doubt as the red, fire-colored fungus known to botanists as the narcotic, hallucinogenic producing mushroom, the *Amanita muscaria*. This is one of the most toxic mushrooms known to man, yet small quantities were eaten by the ancients as a part of their religious ritual much as we celebrate the Holy Eucharist. □

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Continued from page 26

The list of things observable could be quite extensive. The most important thing to remember however is all of the things that the body can tell you without even touching it. It has a potent message if we only develop the ability to listen with our eyes. □

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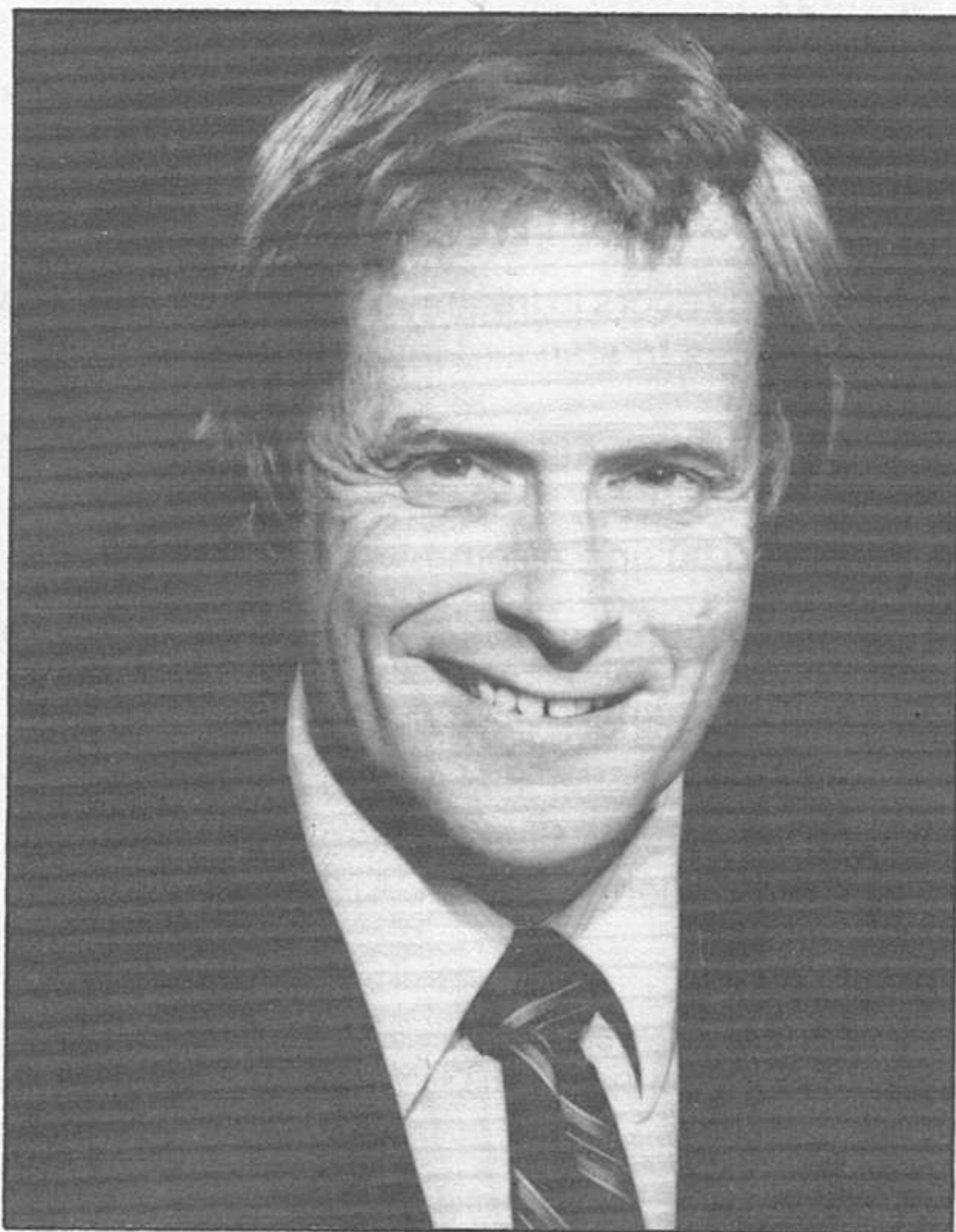
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JULY, 1980

VOL. 2 NO. 5



RICHARD H. TYLER, D.C.

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JULY, 1980

VOL. 2 NO. 5

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THE CHIROPRACTIC FAMILY PHYSICIAN is published bi-monthly by the Council on Diagnosis and Internal Disorders of the American Chiropractic Association, P.O. Box 1577, Glendale, CA 91206.

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PRESIDENT'S PAGE

E.A. Wilson, D.C., Council President

Neuropathy is an evolution from many antecedent evolutions of drugless therapy manipulations, some dating back as far as Herodotus in the 5th century, who advocated exercise for the treatment of disease and compelled his patients to have their bodies rubbed, and was also the first to lay down principles for rational, mechanical methods of treatment. From that time, on down through history, Herodotus, Plato, Socrates and Hippocrates as well as many others gave various principles and explanations of how to give manipulations and what was accomplished by manipulations. For illustration, Hippocrates said "Rubbing can bind a joint that is too loose, and loosen a joint that is too rigid. Hard rubbing binds, soft rubbing loosens, much rubbing causes parts to waste, moderate rubbing makes them grow." This was the first time that information had been given regarding the various effects of different types of manipulation. From that time on until today, there has been accumulated a vast data on the effects of peripheral manipulation, and from these early investigators the groundwork was laid for the development of manipulation and physical therapy as a science and art. □

EDITORIAL

"Opposite Extremes With The Same Goal"

by

Richard H. Tyler, D.C.

We are a profession of extremes. We don't need to go much further than the extremes of the mixers and the straights for an excellent example. For a long time I could understand the straight concept because they spell out their objectives. I don't agree with them but I understand what they say. When they claim that they don't diagnose or treat but analyze and adjust, one can readily accept the fact that they want to be pseudo religious technicians. Aside from everything else it's "safe." Since our profession was built by men of relatively fearless resolution it is sometimes difficult to reconcile some of the professional timidity we now see. We seem to flirt with organized medicine in the hopes we might some day become "engaged." The only thing about that is that the ring would be placed through the nose rather than on the finger. In a recent issue of the New England Journal of Medicine it was postulated that there *might* some day be some acceptance of us as "limited practitioners." How wonderful.

Since we already have our self-ordained "limited" practitioners in the straights it came as a surprise to me that within what we call the mixer segment we have those who apparently also wish a limited status for the rest of us.

Specialty practice is fine — it's fine, that is, if it remains woven within a fabric of the profession as a whole. When one specialty tries to dominate the others, however, by promulgating a therapeutic philosophy that would limit everyone else to a role no greater than the one that they are willing to practice, then we have a foolish and potentially dangerous situation.

(continued on page 5)

SALUTE TO THE EDITOR

Richard H. Tyler, D.C.

Richard H. Tyler, D.C. is a board qualified chiropractic orthopedist. He graduated from the Los Angeles College of Chiropractic in 1969. Graduate studies have included Chiropractic Orthopedics, Diversified and Reflex Techniques and Therapeutic Hypnosis.

Dr. Tyler is a member of the American Chiropractic Association and the American College of Chiropractic Orthopedists, the ACA Council on Chiropractic Orthopedics, the ACA Council on Sports Injuries and the ACA Council on Diagnosis and Internal Disorders.

Civic activities have included work with the Boy Scouts and the Pop Warner Football League. He was the founder and director of the North Hollywood Kiwanis Clinic for Kids.

Professional papers by Dr. Tyler have been published in The Chirogram, The Digest of Chiropractic Economics, The Osteopathic Physician, The Journal of Natural Medicine, Today's Chiropractic and The Journal of Clinical Chiropractic. He is presently the Editor of The Chiropractic Family Physician.

Dr. Tyler has been a lecturer on the faculty of the Graduate Education Division of the Los Angeles College of Chiropractic.

Dr. Tyler was an actor for 26 years. In 1946 he starred on Broadway in Moss Hart's "Christopher Blake" and won numerous acting awards, among them "One of the 10 Outstanding Performances of the Year" and "Best Performance by a Young Actor." He also played "Henry Aldrich" on the T.V. show "The Aldrich Family" in the 1950-51 season.

Dr. Tyler was both the Boy Scout and Sea Scout in the Norman Rockwell Boy Scout calendar painting for 1951.

For seven years he was the West Coast Editor for "Muscle Builder" and "Mr. America" magazines and during this time he authored between 700 to 800 feature articles. Dr. Tyler also holds a purported world record in strength with a seated one-arm concentration curl of 154 lbs. at a 165 lbs. body weight. In 1976 he competed in the Highland Games as a wrestler in Oban, Scotland.

The Chiropractic Family Physician is proud of Dr. Tyler for his work as our Editor and for his fearless stand and his ability to articulate his views on the vital issues of the chiropractic profession. We salute him for the fine job he is doing as our Editor. □

(Continued from page 4)

The other day I had a conversation with a doctor whom I have known and admired for years. He is deservedly one of the leaders in his specialty and an influence in the profession. As our conversation progressed he mentioned that he felt that the Council on Diagnosis and Internal Disorders was getting into areas that could invite legal problems. "In what way?" I inquired. I listened as he told me of the dangers found in diagnosis, especially since we have limited access to sophisticated diag-

nostic instrumentation, and of the dangers inherent in treating anything but what his specialty did. I got the definite impression that he would be happy if the entire profession became the specialty he practiced.

While I respect the doctor, I disagree with him on almost every point. In the first place we aren't limited in our use of diagnostic instrumentation. Most of us in the larger population centers have complete access to lab facilities. In some states the chiropractic physician even has the lab as part of his office. In rural communities a good diagnostician does the examination in his office the same as his medical counterpart with the *added* dimension of a structural evaluation and in many cases Applied Kinesiology or other reflex diagnostic procedures. In other words, the average chiropractic diagnostician often has the tools to do a *better* job than those in the other health disciplines.

As far as treating is concerned, I cannot conceive of auscultating a cardiac arrhythmia without adjusting the cervicals and the upper thoracics any more than I could conceive diagnosing digestive problems without advising on diet and the use of specific supplementation. To do less is to deny the patient the conservative health care that we have been trained in and taken an oath to perform.

There is always someone fighting to restrict what we do within the profession from *both* our philosophic extremes. Why? Why can't we stop painting ourselves into a therapeutic corner? Apparently we do this for two major reason — either because of philosophy or out of fear. While the first reason is stupid, the second is tragic. We are a first-rate *complete* health discipline filled with broadly-trained, well-educated men and women. To do less than we have been trained to do and thereby expose the patient to often needlessly radical procedures is inexcusable. By the same token it is *essential* that we know the limits of what we have been trained to do and therefore establish a meaningful dialogue with other health professionals in our respective areas for consultation and referral.

Fear is an ugly word. If we want to "play it safe" we shouldn't even be in practice or, for that matter, get on a freeway or cross a street. Life in a profession like ours, however, requires the confidence that can only be built upon education. Yes — we all may ere diagnostically, some more than others, but if we aren't willing to take chances in helping people then we should play it safe completely and leave a profession which requires an oath from its practitioners to dedicate their lives to the risk of failure but the reward of having tried. □



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by
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When we discuss epilepsy we are, indeed, in noble company. Julius Caesar, Alexander the Great, Lord Byron, Feder Dostoevsky, Van Gogh, and Alfred Nobel are just a few of the famous epileptics. Among theologians there is a good deal of speculation that the oft complained of "burden" that St. Paul complained of was epilepsy.

To begin with — epilepsy is not a disease — it is a symptom — a manifestation, or function of another condition. There are many different types of epilepsy, each requiring a somewhat different therapeutic approach.

The cause of epilepsy may be unknown, or it may be due to a space-occupying lesion in the brain, or due to a birth injury. It may be the result of a small scarrified area upon the cortex of the brain, or because of intracranial pressure. So the consideration of this condition is both fascinating and complicated. It may manifest itself as a very mild petit mal seizure, in which the patient may lose consciousness for a few seconds, or even a few minutes, never knowing that he has been "out," or he may lapse into a dreamy state and experience feelings of unreality. He may have hallucinations of smelling bad odors. This, all the way up to the highly dramatic grand mal seizure where he vocalizes a high-pitched whinneying sound, convulses, falls to the ground, chews his tongue, and becomes incontinent and "wets his pants."

Should the patient experience a fall during a grand mal seizure, the doctor should examine for injury, and possibly x-ray. This is not only for the patient's well being, but also for the doctor's legal protection.

Diagnosis: The diagnosis is established principally by the case history. A history of black-outs or feelings of euphoria, might be suspicious of epilepsy. Brain wave tracings may or may not be helpful. If the tracing is made during an episode, the pattern will be unmistakable, but in quiet periods, the EEG tracing may appear very normal.

The body should be examined for scars, or other evidence of frequent injuries. The tongue should be examined for evidence of chewing. Look also for oral lesions or evidence of cracking or fissuring of the lips, especially at the corners of the mouth.

Laboratory tests and clinical evidence for hypoglycemia should be included in the diagnostic work-up, as should a Serological Test for Syphilis. (Syphilis, you know, is often called "the great imitator.")

Activity: The patient should remain active. The active and busy patient seems to have fewer seizures.

Diet: The epilepsy patient may follow a rather normal diet. The diet should be high in protein. Carbohydrates should be limited. Heavy meals, and heavy intake of milk should be avoided.

Nutritional: The nutritional necessities for the epileptic patient should consist of the following: an adequate intake of B₆, pyridoxin, which must depend upon an adequate intake of Riboflavin. A riboflavin deficiency leads to a pyridoxin deficiency; in fact, the oral lesions often associated with riboflavin deficiencies are now thought to be pyridoxin deficiency lesions. As digestion is very important in these cases, an enzyme formulation, or, in cases of petit mal, glutamic acid hydrochloride has been suggested as helpful.

The publication "Present Knowledge in Nutrition," in 1976 mentioned manganese as important in brain function, stating that it could affect the brain by either its deficiency or its excess; however, there was no mention of epilepsy per se. Other sources have, from time to time mentioned manganese as beneficial to brain and nerve tissue, but we seem to be lacking in solid classical evidence to substantiate this.

Hunt et al and Bessey et al has pointed out that B₆ functions as a vitamin coenzyme for various metabolic reactions concerned with amino acids. Riboflavin is necessary for the physiological activation of B₆.

Bessey speculated that a derangement of amino acid metabolism may be intimately related to seizure activity. The effect seems to be the amino acid - γ - aminobutyric acid pathway.

Education: Education of the epileptic patient, and of the family, and associates of the patient is an essential ingredient in keeping the patient emotionally stable, and more amenable to his therapy — whatever it is. Probably no other condition is so feared, and so immersed in superstitious speculation than is epilepsy. Here are some frequently asked questions — with straight answers.

Q. Is epilepsy hereditary?

A. There is no evidence to show that it is hereditary. As with any other condition, there may be a tendency toward seizure where a strong family trait is shown, but nothing indicates that it can be passed from parent to child.

Q. Does the condition worsen with age?

A. No. The pattern, once established, usually remains stable.

Q. Is mental retardation or insanity a part of epilepsy?

A. This is probably the most vicious of all of the misinformation. Of course a mentally retarded person may be an epileptic, but this in no way means that all epileptics are mentally retarded, or that there is a lack of normal intelligence. Remember that epilepsy is a symptom — it does not cause anything. The famous people mentioned in this monograph were hardly "nuts."

Q. Is it a rare, or a common affliction?

A. It is very common. There are over two million epileptics in the United States, and probably in excess of twenty-five million in the world. The epileptic is not *that* different from other people.

(Continued on page 20)

LOW BACK INJURY WITH PAIN DUE TO LUMBAR DISC RUPTURE Non-Invasive Care

by
R. J. Wiehe, D.C.

It is always more desirable to use non-invasive methods of examination and treatment if at all possible when treating the human body.

Obviously, with the utilization of invasive methods such as injection of dyes, as in a myelogram or reduction surgically, there is always the possibility of some damage done by the invasion and occasionally the danger of death due to unforeseen complications.

This discussion will deal with the alternative of non-invasive care for the ruptured disc. We shall divide this paper into three subjects dealing with injury to the low back.

- I Description of the injury
- II Non-invasive diagnostic procedures
- III Non-invasive treatment — CRDT

I. THE INJURY

A low back injury can affect all tissues of the low back; bones, muscles, nerves, ligaments, joints, bone covering, and the most common — damage to the intervertebral disc.

A. *Bone.* Bone is often not affected by the injury. However, compression fractures occur occasionally, especially if there is a pre-existing osteoporotic condition.

B. *Muscle.* Most often strained, occasionally sprained with tearing of the ligamentous attachments.

C. *Large supporting ligaments.* Only injured in very severe injuries.

D. *Joints.* Frequently the posterior joints (zygapophysis) are damaged or interrupted. This damage causes back pain. It can lead to disc problems.

E. *Intervertebral disc.* The most common site of injury. It is ultimately responsible for leg pain, numbness and tingling. There are four grades of injury to the intervertebral disc, the last three constituting disc herniation.

Grade 1. *Swelling or edema of the disc.* Results in some pressure on the nerve roots and results in back pain. This disc condition is short-lived and within a few weeks symptoms of this problem will disappear. Recovery can be hastened by CRDT. Average treatment time 2 weeks - 8 months.

Grade 2. *Confined disc bulge.* The outer rim of the disc will have a shallow bulge sufficient enough to entrap nerve roots and cause somewhat the same symptoms as

problem No. 1 and can also cause pain in a leg. This condition will take somewhat longer to correct. Average treatment time 90 days.

Grade 3. *Disc protrusion with torn annular fiber.* In this condition the nucleus has shifted well to the outside of the disc and there is a large bulge jamming up against nerve roots. Although the annular fibers have partially torn they still are able to contain the nucleus of the disc. This is severely painful and can be corrected by *closed reductive disc therapy* (CRDT); however, the treatment is of considerable length. The low back pain is severe. Eventual severe leg pain. Average treatment time 8 months.

Grade 4. *Total nuclear prolapse or nuclear herniation.* In this situation sufficient tearing and separation of the annular fibers of the disc have occurred to allow the nucleus to be squeezed outside of the disc itself. This is the most severe of all disc herniations. Correction of this problem can take as long as two years.

It is extremely painful and generally results in severe sciatic radicular pain with slowly progressing muscular atrophy in the affected leg. Average treatment time 16 months.

GENERAL COMMENTS: Disc herniations affect the nerve roots of the lumbosacralplexus resulting in severe pain in the back and leg and/or most often neurovascular spasms resulting in numbness and tingling with accompanying atrophy of the leg muscle.

In the beginning the pain is noticed primarily in the low back region. It is generally aggravated by sitting, bending, stooping, or twisting. It can be relieved, sometimes, by walking and by lying down. Much of the pain of the low back is due to a combination of involvement of the posterior vertebral joints and the disc.

As the condition continues, and if the condition is not corrected, the pain generally leaves the low back area traveling down into one hip or leg with the resulting paresthesia. It may continue in both the back and leg depending on the amount of joint damage.

II. DIAGNOSTIC TEST

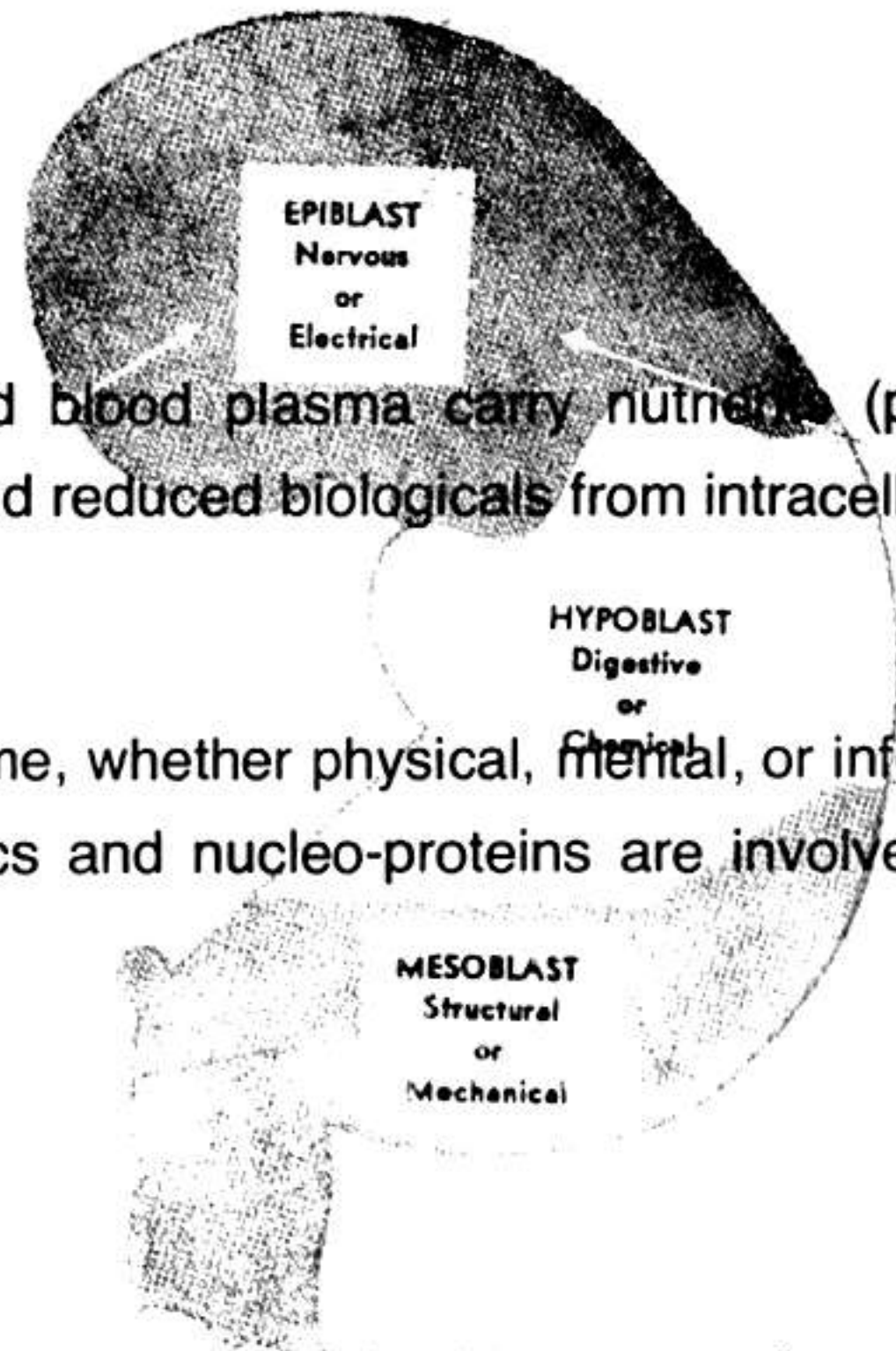
Diagnostic Tests – Non-invasive. Let's first discuss invasive diagnosis. The myelogram has been misunderstood not only by the laymen but also by the general practitioner. The injection of dye into the spinal column to determine the site of disc protrusion is a procedure that should be used only after adequate orthopedic and neurologic tests and all prescribed non-invasive treatment have been conducted. It should be the conclusion of at least two doctors that the particular injury cannot be cured by closed reductive means; finally, the pain should be so severe and unbearable that surgery is the only alternative. The myelogram is not used as a diagnostic or differential diagnostic tool, but is used *only to show the surgeon where to go to perform his surgery.*

Non-Invasive Diagnostic Tests. These tests follow a good history of the complaint.

1. *Orthopedic-Neurologic Tests.* The physician should employ a group of orthopedic-neurologic tests that are conducted while the patient is sitting, lying,

(Continued on page 12)

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(Continued from page 10)

standing and bending. In these tests the patient will either bend himself, raise or lower his legs or will have the physician do the bending, raising, or lowering of the limbs for him. The suspected involved nerves, joints, or discs, are manipulated, stretched, compressed or otherwise stressed so as to elicit or exaggerate a painful response. Each test has its own significant meaning related to the location and severity of disc involvement.

2. *Observation.* The gait and posture of the patient are observed as is the skin color of the suspected involved limbs.
3. *Sensory evaluation.* The limb of complaint is evaluated by pin pricking.
4. *Temperature Variations STUDIES.* These are made with an electric thermometer to find cold spots on the legs.
5. *Palpation of Muscles and Trigger Points.* This examination evaluates pain points — muscle tone, muscle resistance, muscle spasms or flaccidity.
6. *Measurements of controlateral circumferences* of the limbs to determine atrophy of muscles.
7. *Superficial and deep reflex tests.*
8. *X-rays of the site of involvement* as well as the site of pain. Studies are not only examined to determine damage and stress but also to differentiate or rule out other damage, fracture, pathology.
9. *Measurement of the range of motion* of the area of injury and the limbs affected.
10. *Muscle testing for strength* of the affected limb and the controlateral limb.
11. *Palpation of the bony structures* at the site of injury to determine alignment and proper kinesis.

DIFFERENTIAL DIAGNOSIS. Blood pressure of the affected limb and controlateral limb as well as the other two limbs of the body at different levels should be taken. A comparison of these blood pressures gives a good determination as to whether or not blood flow has been affected by the injury. If blood flow is abnormal, plethysmographic and doppler examinations should be conducted to determine whether they are indeed neurovascular problems due to the injury or possible pre-existing vascular problems, particularly of an organic nature.

BLOOD CHEMISTRIES. Blood chemistries need to be evaluated to determine the presence of any possible bone lesion such as cancer, or pathology that would either cause similar symptoms or delay the healing process. *Example:* High Uric Acid indicating gouty arthritis would affect the injury.

III. TREATMENT

TREATMENT (CRDT). Closed reductive disc therapy.

In order to understand the non-invasive treatment of low back disc rupture, we must talk briefly about the causes of disc herniation. A number of authorities agree that a large majority of disc herniations brought about by a single episode or injury had pre-existing conditions that caused a weakness or instability of the disc enabling the rupture to take place.

(Continued on page 14)



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The following are some conditions that can pre-dispose the low back to weakness and thus disc herniation.

1. Misalignment, rotation, subluxation, postural deviation, scoliosis, and other abnormalities relating to the position, posture or kinesis of the lumbar vertebra and the lumbosacral pelvic bones and articulations.
2. Overweight.
3. Weakness, atrophy, spasm, unilateral spasm, contralateral unbalance, or general poor tonicity of the muscles and/or ligaments supporting the lumbosacral pelvic articulation.
4. Degenerative atrophic changes of the bones, discs and joints of the low back.
5. Metabolic disturbances or abnormalities in the individual, particularly those that would affect the metabolism of bones and joint structures and the body's utilization of minerals and certain vitamins such as C and A.
6. Congenital defects or atypical development and formation of the bones and supporting structures of the low back and pelvis.
7. Disease and pathology of the low back and pelvis, such as cancer, arthritis, TB, benign tumors and other pathologies.
8. Weakness of the lumbosacral pelvic articulations due to frequent repeated micro-trauma or stresses associated with particular types of occupations.
9. Malposition, development or disease of the posterior joints (zygapophysis).

If the examiner takes a proper history and conducts a thorough and detailed examination and has the knowledge and capability of evaluating his findings, he then has the necessary ingredients with which he can design an effective treatment for the correction and support of the herniated disc.

Such a treatment regimen should include removal of stress situations and the reversal of unbalanced or abnormal stress pressure vectors creating unilateral hydrostatic pressures on the disc nucleus which are responsible for forcing that nucleus lateralward into the periphery where nerve root entrapment takes place.

Treatment also involves supportive care during the healing process. Adequate scar tissue is necessary to support the injured disc sufficiently to return the patient to normal work activity.

The optimum or desired effect is to repair the damage sufficiently so that the patient can once again place normal stress loads upon the injured joint without causing additional damage or pain.

In some cases of severe disc damage, that degree of correction is not possible. However, if the patient can be restored to a relatively bearable minimum amount of pain even though work stress is not capable, the treatment program is considered to be successful. The patient will have to relegate himself to doing work that will not stress the site of injury in the future. Failure to properly correct a herniated disc will result in a steady, gradual deterioration of the disc and vertebral body until degeneration and hypertrophic changes destroy the entire intervertebral space and severe permanent damage occurs.

(Continued on page 28)

(Continued on page 28)

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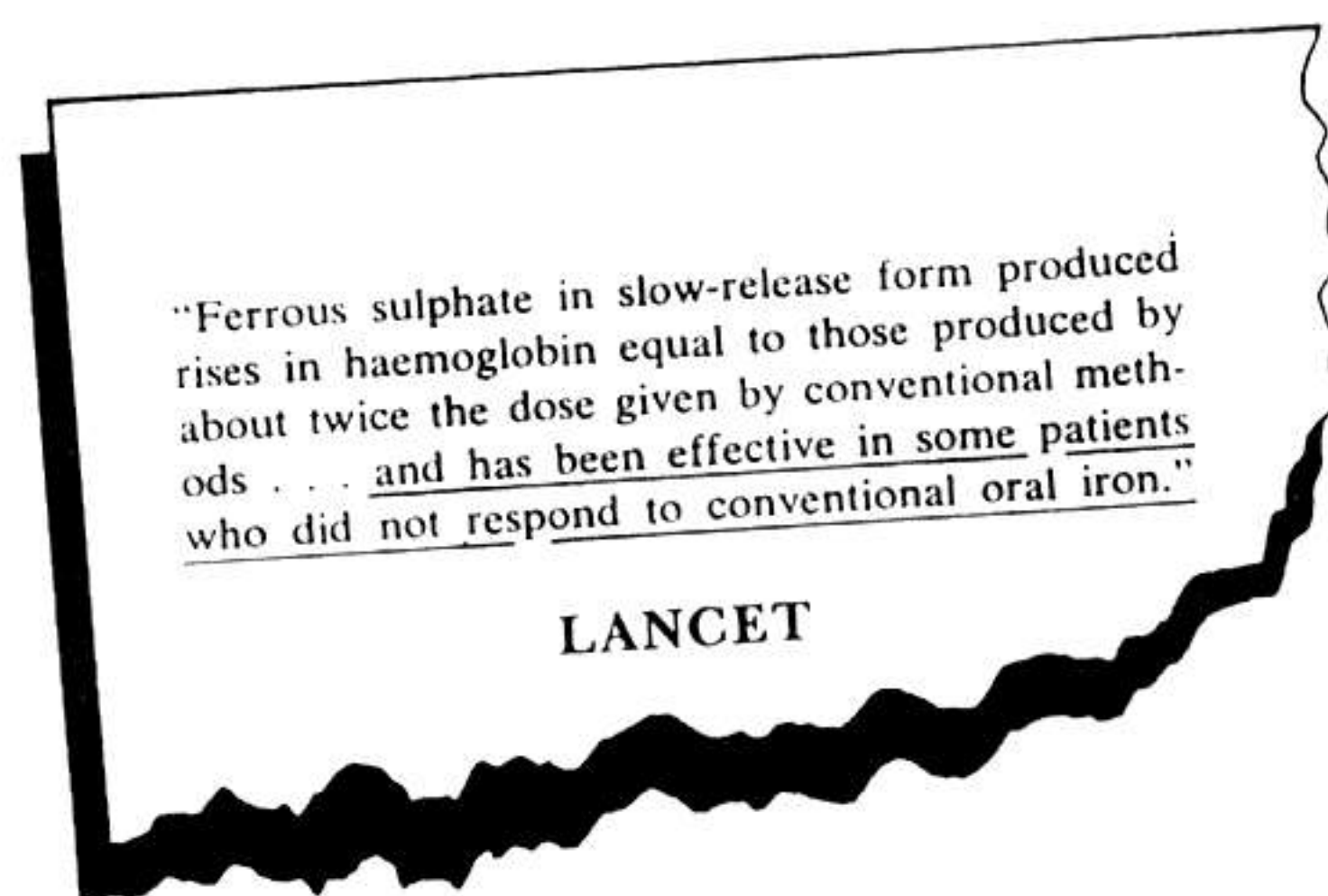
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TRACTION THERAPY FOR LUMBAR DISC PRESSURE

by
Ralph J. Martin, D.C.

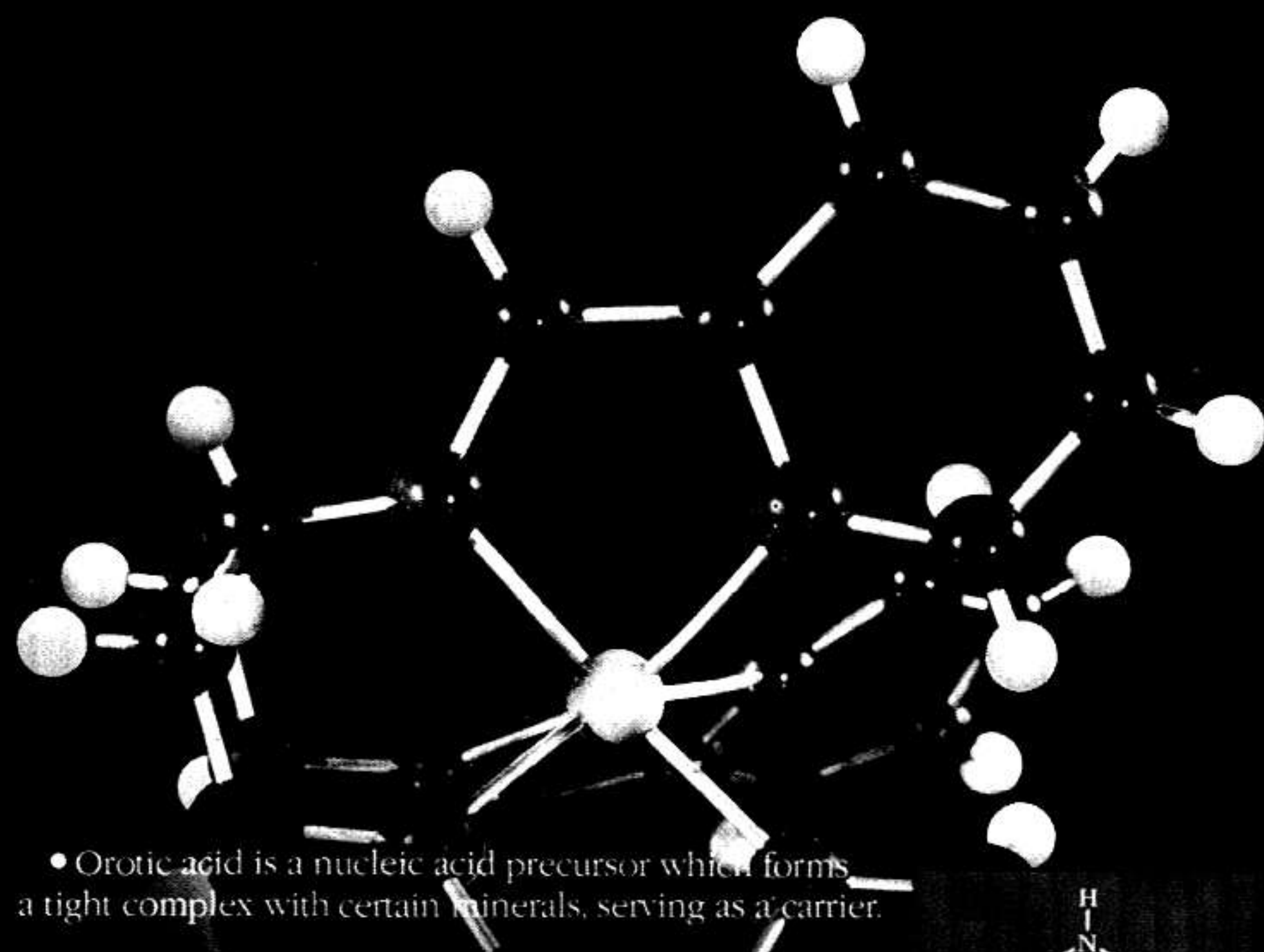
Historical Background: In December, 1950, I had a severe low back case, a male, age 56, which X-rays showed a very close approximation of the bodies of L5 and S1 on the left side. Pain was so severe the patient was totally confined to his bed and any movement at all in the bed was excruciatingly painful. At that time available traction equipment for the lower back was applied either at the ankles or knees and was synonymous with the medieval torture racks of the inquisition.

I had an idea as I studied to find a way to correct this case of obvious unbearable pressure on the disc below the body of L5 that if the patient could be kept in bed for two or three weeks with just enough traction to ease the pressure entirely on the injured disc, the healing process would be initiated and would carry away the excess fluids of inflammation, replace the normal original disc with a tough and permanent scar-tissue disc. I hoped also that the debris of the crushed disc which was impinging on the nerve root would be carried away as the healing process was completed.

I felt this theory to have sufficient merit to outweigh the hazards of surgery. Since I was serving at that time as president of the Los Angeles College of Chiropractic, I called in the representatives of the Camp Orthopedic Appliance Co. from the Hollywood office to meet me at my office at the college and gave them specifications for constructing the apparatus that I wanted. As they began to understand my idea they became very enthusiastic and excited about it (which I should have made note of as a signal of what would happen a little later) and went back and produced the equipment that I had specified.

This consisted of a strong canvas pelvic belt 8 inches wide with a 'velcro' closure. One-inch wide straps were attached to the side of the belt which were adjustable in length so they would always be long enough to extend several inches beyond the patient's feet, where the straps were securely attached to 3/4" by 2" wood piece 24 inches long which had a hole in its center, 12 inches from each end. A strong clothesline or window cord was put through the hole. The cord was long enough to go a foot or two beyond the foot of the bed where a three-foot or four-foot stepladder was placed and a pulley secured to it at a level with the top of the mattress. Weights ranging from 20 lbs. to 30 lbs., depending upon the size of the patient, were secured to the cord which had passed through the pulley. The next step was to raise the foot of the bed 4 to 6 inches so the patient would be sliding gently headward and the weight which was pulling from the patient's pelvis, balanced the headward gravitational pull of his body. This I have termed an "Antigravitational Balanced Traction." In this apparatus the patients are so comfortable there is no problem keeping them in it through the critical first ten days of the therapy. They can even turn on their sides occasionally to relieve the tedium of the supine position.

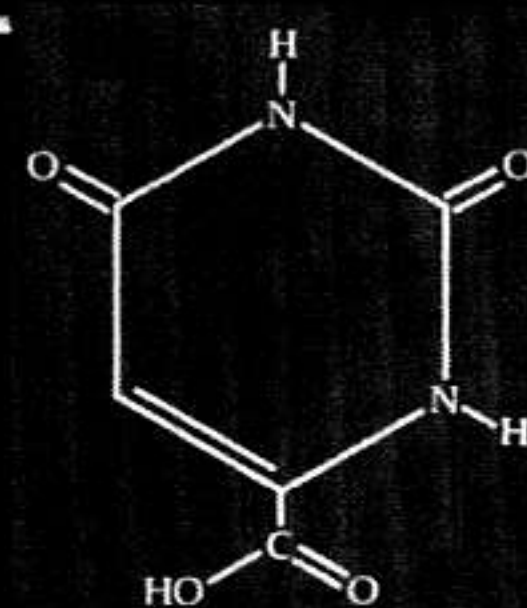
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(Continued from page 17)

This first patient was a painting contractor who spent most of his working hours on ladders and scaffoldings. He was put into traction with this unit on December 6, 1950. The first 10 days he was allowed no bathroom privileges and had to use the bedpan. After 10 days he was able to go to the bathroom comfortably but no other ambulant activities. He was still in full-time traction 24 hours a day. We found on this first case that the amount of weight that provides the patient the maximum freedom from pain was the right amount of traction. Too little weight did not separate the disc-space enough to relieve the impinging pressure. Too much weight pulled the disc-space too far apart and constituted a new traumatic factor.

At the end of three weeks the patient was permitted freedom from his 24 hours of traction daily and spent only 2 to 3 hours in traction each day and about an equal amount of time at night, usually when first retiring.

On March 2, 1951, 90 days after the traction program was first initiated, the patient returned to his job and after a couple of weeks of testing himself, he settled in to his usual working routine. He had no recurrence of symptoms from the traumatized disc for the remainder of his working productive years.

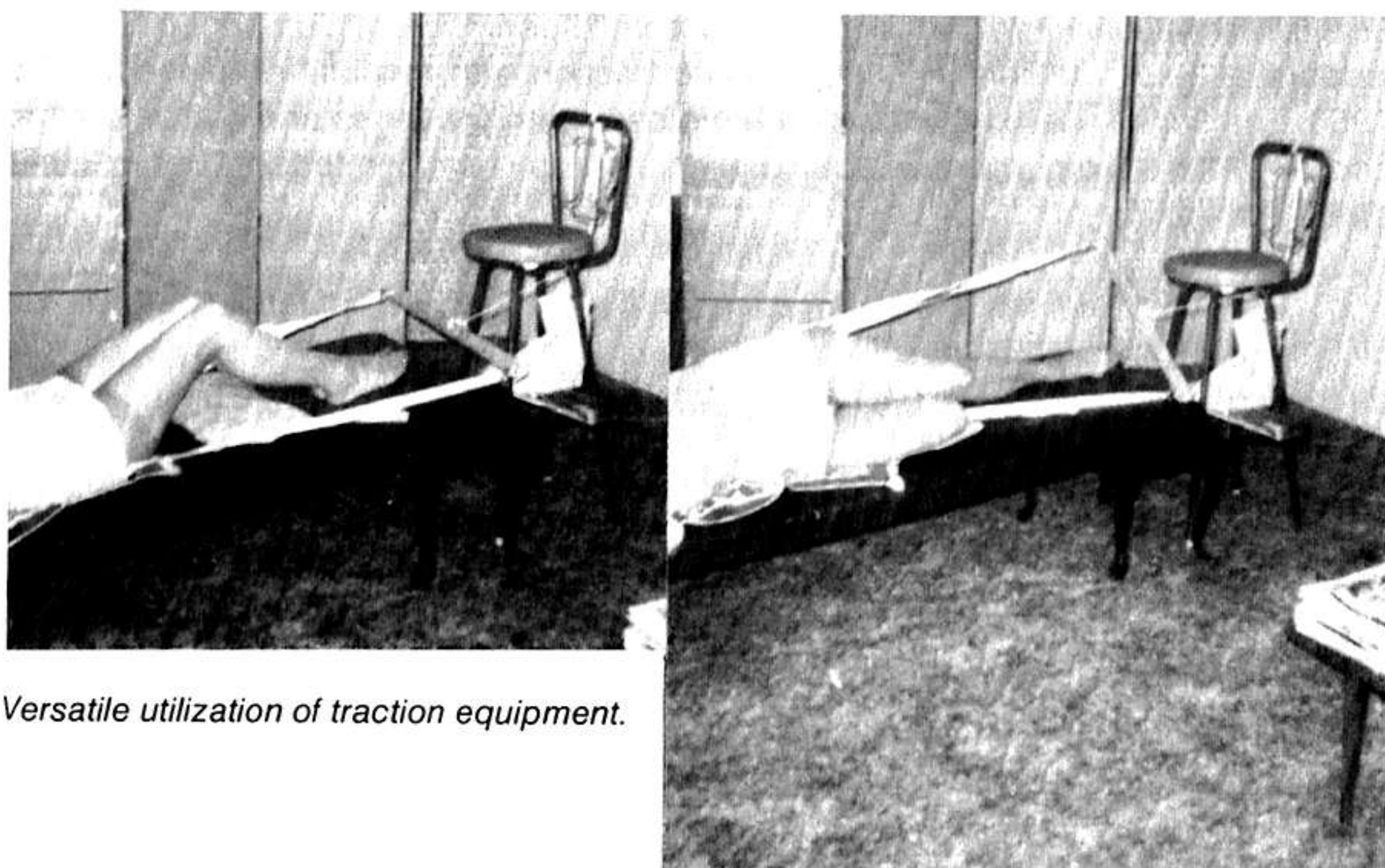
Footnote: A year later the Camp Company came out with this apparatus in its new catalog and have featured it ever since. My first case proved my theory to be worth pursuing further, but also proved that I was a poor businessman. I am informed by patients who work in supply rooms of large hospitals that there are hundreds of these units in use at all times. There seems to be one flaw in their procedure: if a patient has not responded substantially in about three days he is scheduled for myelograms and surgery. This is an outright prostitution of the apparatus because three days is not enough to prove anything. My experience has shown that the time required in constant traction is from 10 days to 6 weeks.

The experience with this first patient has been repeated many, many times and has been uniformly successful except in one case in which traction to the traumatized disc was comfortable to the area but produced a referred pain at D7 and D8 which was never satisfactorily explained. This case was referred to the Veterans Hospital in Long Beach, California, and there the traction unit produced the same pain as before at D7 and D8. Surgery was performed for the disc and was exceptionally successful for as long as I was in touch with the patient.

There is one anomaly in which this form of therapy must be used with extreme caution, if at all. This is the anomaly in which the transverse processes of the L5 fuse with the sacrum or the ilium on each side or to both the sacrum and illii as in the 'butterfly wing' anomaly. Traction to these cases runs the high risk of breaking the fusion and creating a new problem that may be just as painful as the disc pressure trauma.

I dislike very much the usual terminology attempting to describe the disc lesions. Since pressure is the problem I prefer to refer to the degree of pressure found to be present in each case.

There has not been a year since 1950 that I have not had some occasion to utilize this gravity balancing traction unit on a number of cases with uniform satisfactory



Versatile utilization of traction equipment.

results and grateful patients who always are hopeful of avoiding surgery with such a successful alternative. I am convinced that with proper utilization of this equipment there would be less than 5% of disc surgery that is currently prevalent. This is another area in which chiropractic family physicians can demonstrate superiority over prevalent procedures currently in use. □

(Continued from page 8)

Q. Can an epileptic work normally?

A. As long as the seizures can be controlled, he can and should work normally. Most states will issue Drivers' Licenses to controlled epileptics.

Q. Is epilepsy contagious, or "catching"?

A. No way, any more than a broken bone or a bursitis is "catching."

Q. Can the epileptic always anticipate a seizure?

A. Some patients, yes, particularly in grand mal. In petit mal — generally no.

Epilepsy then is an effect, a result.

There are over 20 different forms and types of epilepsy, each requiring a somewhat different therapeutic approach.

It is an extremely complex type of problem.

With our present body of knowledge, it is not curable, but its effect, the seizures, can be to some extent controlled.

Management involves control of the seizures, and to date, this is accomplished only by drug therapy, although no single drug controls all main types.

(Continued on page 29)

LETTERS TO THE EDITOR

Dear Ralph:

I thought I should drop you a line to tell you how much I enjoyed receiving The Chiropractic Family Physician journal which you are editing. I feel that it is well done and the articles are certainly most appropriate and interesting and timely.

I am going to enclose a check for ten dollars to cover the annual subscription cost. I have apparently been receiving it gratis which I have appreciated.

Glad to hear that you are active and contributing to the profession like you have in the past.

My sincerest best wishes.

Very sincerely,
R. F. Schmidt, D.C., P.C.

Dear Richard,

I read your editorial in the recent issue of the Chiropractic Family Physician and want to take the opportunity to tell you that I understand your feelings and frustrations. For one, I do attempt to read your fine Journal and have always followed your writings as I basically agree with you on these issues. Certainly diagnosis is the portal through which a patient enters any form of care. Our profession is lax to this end and we do seek to be better businessmen than doctors in many cases.

Continue your work knowing that it is the proper direction for the profession. Having served as President on Roentgenology of ACA, I can share your frustrations at times. In the end, we will win.

Allow me to encourage you and to let you know that many of us are making a worthy effort and that it is appreciated.

Sincerely,
James M. Cox, D.C.

Dear Dr. Tyler:

Your March editorial entitled, "A Matter of Priorities," was quite appropriate for our profession. Unfortunately, there are too many of our brethren who would rather, "Pop a Back," and let innate do the studying.

This was their philosophy in school, and now in their practice. To compensate for their academic inadequacy, they have a predilection for the Vegas carnival life. I'm not opposed to increasing one's life, but not at the expense of employing con-like sales techniques in dealing with health matters.

Common sense and a firm foundation in the basic sciences yields a therapeutic ambience that results in referrals, financial comfort and self pride. Pride resulting from being a successful doctor of chiropractic, not a **doctor of sales care**.

I certainly intend to take the course in Diagnosis and Internal Disorders, and every other course that will enhance my knowledge of the human body.

Sincerely,
Christopher Wilkerson, D.C.

NUTRITION FOR THE WHOLE PERSON

From APPLIED TROPHOLOGY

Vol. 22-No. 3 — 3rd Quarter, 1979

Editorial Statement:

This article is published with the kind permission of Standard Process Laboratories, Inc. and the author Norman Swift. It provides a reasonable presentation of a currently controversial subject. The Chiropractic Family Physician takes no position which could be construed to in any way restrict the freedom of the chiropractic physician to use nutritional substances that may benefit his patients. We appreciate the opportunity to make this information available to our readers.

**"The physician should not treat the disease
but the patient who is suffering from it."**
—Maimonides, 800 years ago

Simply put, trophology is the study or discipline of nutrition. The expression is lifted from the Greek **trophe**, meaning nourishment, and **logos**, word or study. In these fast-moving times, with a veritable flood of newly learned detail about human physiology pouring in on us, there is no shortage of facts. The difficulty lies in making these facts meaningful, in applying them. Thus one who wishes to be a student of applied trophology may take in abundant facts from reliable sources available to him, but more importantly one must learn to put them in perspective. This journal attempts to help the thoughtful health-care professional do just that, always within the basic framework of good balance and common sense, with an eye to the whole person.

The Spaces Fill In

The information deluge may be just beginning. The biologic revolution is still young. In his delightful series of essays entitled "The Lives of a Cell," the accomplished physician and researcher Lewis Thomas notes: "It is a curious, peaceful sort of revolution, in which there is no general apprehension that old views are being outraged and overturned. Instead, whole, great new blocks of information are being brought in almost daily and put precisely down in what were empty spaces. The news about DNA and the genetic code did not displace an earlier dogma; there was nothing much there to be moved aside. Molecular biology didn't drive out older, fixed views about the intimate details of cell function. We seem to be starting at the beginning, from scratch."

Reflect on that pioneer of molecular biology, Dr. Royal Lee. Today one can only note the empty spaces are being filled in. We have sound physiological and biochemical rationale to support even those empirical approaches which he found to have clinical validity. Take, as an example, the prostaglandins, first found in the prostate, seminal fluid and vesicular glands. They are now known to be of very wide distribution in mammalian tissues, in the kidney, thyroid, spleen, endometrium of the

(Continued on page 24)



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EXOCRINE PANCREATIC INSUFFICIENCY AND STEATORRHEA

Graham¹ showed that **in vivo** potency, or potency in the patient, correlated well with the test tube, or **in vitro**, enzyme potency. He studied the reduction of steatorrhea which can originate in humans from cystic fibrosis, alcoholism, and surgical resection of portions of the pancreas. He found **uncoated tablets effective in reducing steatorrhea by 56.1 ± 9%. Enteric coated tablets were less effective at 20 ± 13% reduction.**

The highest potency product studied by Graham was a product called Illozyme which contained 3600 U/unit lipase. Pan-5-Plus contains 4253 U/unit lipase. It is the highest potency pancreatin available.

Azeotropically processed 4NF pancreatin was studied by Graham².

"What is clear—is that the administration of these high potency digestive aids, along with meals, does have very positive clinical influence on reducing malabsorption through improved digestion—when comparing a healthy pancreatic-sufficient individual to one with pancreatic insufficiency, the use of azeotropically processed pancreatin with meals greatly increases the fat-splitting enzyme activity in the duodenum to nearly normal levels."³

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Additional research using azeotropically processed pancreatin have shown it is **effective in B12 Absorption, Pancreatectomy and Gastrectomies, Chronic Pancreatitis, and Cystic Fibrosis.**

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REFERENCES:

- ¹ Graham, D.Y., Enzyme replacement therapy of exocrine pancreatic insufficiency in man, N. Engl. J. Med., 296, 1314 (1977).
- ² Bland, Jeffrey, Glandular-Based Food Supplements: Helping to Separate Fact From Fiction 1979-80. (1980).
- ³ DiMaggio, E.P., Comparative Effects of Antacids, Cimetidine and Enteric Coating on the Therapeutic Response to Oral Enzymes in Severe Pancreatic Insufficiency, N. Engl. J. Med., 297, 854-858 (October 20), 1977.
- ⁴ Gyr, K., Felsenfeld, O., and Zimmerli-Ning, M., The Effect of oral pancreatic enzymes on the intestinal flora of protein deficient Vervet monkeys challenged with Vibrio cholerae, Am. J. Clin. Nutr., 32, 1592 (1979).

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(Continued from page 22)

uterus, and so on. Dr. Lee anticipated their discovery and arachidonic acid as their precursor by some thirty years! These and other exciting new developments deserve to be given attention in the future. But in this issue we would like to set forth some simple premises on which someone may build who wishes to master the art of applied trophology.

A basic truth is that man is integrally linked to his food supply and intake. His organ systems biochemically respond to changes in intake, but always within the parameters laid out genetically for the function of the organism. Thoughtful physicians or dentists may wish to avoid introducing foreign or alien substances into their patients unless they cannot avoid it. Drugs simply do not have single effects and may produce a multitude of undesirable effects, known and unknown. One must always remember the whole patient. If this is true with drugs, it must also be true even when one uses so-called natural substances. Let us start our examination of basic concepts by a simple review of vitamin function.

Megavitamins — Contradiction in Terms

What is a vitamin? It is an organic substance in minute amounts to sustain the normal metabolic processes of life, which the body cannot make for itself — at least in sufficient quantity. Vitamin function is essentially coenzyme function. That is to say, when a vitamin enters the body as a component of food. It travels to the cells that need it and is converted into a conenzyme form if it is not already in that form. It

attaches to a protein made within the cell called apoenzyme. The complete combination of apoenzyme and coenzyme serves the vitamin function of catalyzing metabolic reactions. When the cell is making apoenzyme at maximum capacity, any extra coenzyme cannot possibly serve its vitamin function because it cannot bind to apoenzyme.

A basic fact emerges. By definition, megavitamin therapy is a contradiction in terms. That is not to say it does not have an effect on the organism. It does. But that effect must be a chemical one. Megadosages can serve only as chemicals and not as vitamins. It may achieve certain results, but let us not make the mistake of assuming that result is a natural one or that it will not produce side effects that are undesirable.

Effects of Excessive Fat-soluble Vitamins

Once one grasps the concept of megadoses as having chemical rather than vitamin effects, it is not surprising to learn of side effects from excess ingestion of even substances previously thought to have no toxicity. Let us first look at one of the fat-soluble vitamins in that category, vitamin E. With large doses there are reports of inflammation of the mouth, chapping of the lips, muscle weakness and/or cramps, gastrointestinal disturbances, hypoglycemia, increased bleeding tendencies and degenerative changes. In large dosages vitamin E antagonizes the action of vitamin A, perhaps explaining reports of blurred vision in recipients of megadose therapy. Headache, nausea and fatigue are also reportedly side effects of megadose therapy with vitamin E.

This should not be surprising. The vitamin E-deficient animal presents a baffling array of apparently unrelated histopathologic sequelae. Obviously vitamin E is not a substance with single effects. Evidence mounts that it is not simply a biological antioxidant but a component of multiple enzyme systems. Too, interaction between various vitamins has been demonstrated, as with vitamin A compounds and other members of the lipid class. Vitamin A metabolism is linked with that of coenzyme Q, vitamin E, vitamin D, the sterols, and the biosynthesis of squalene (intermediate in cholesterol production). This is part of the difficulty in researching the exact function of various substances. Truly Royal Lee was correct in describing vitamin activity as "wheels within wheels."

Effects of excess vitamin A ingestion are well known, but a review may be helpful. One of the main functions of vitamin A is to maintain membrane integrity by providing cross-linking between the lipids and proteins. Excessive amounts of vitamin A combine with membrane lipoprotein and cause instability. Arctic explorers eating large quantities of polar bear liver experienced such toxicity. The syndrome is characterized by drowsiness, headache, dizziness and diarrhea, caused mainly by cerebrospinal fluid pressure. Increased blood levels of vitamin A are found in persons with lipid nephrosis and glomerulonephritis. These patients are intolerant even to ordinary amounts of this vitamin. Chronic ingestion of inordinate amounts of vitamin A result in a cirrhotic liver syndrome that includes portal hypertension. Other results may be hypercalcemia, swelling over the long bones and premature epiphyseal closure. Early signs may include coarse sparse hair, alopecia of the eyebrows, dry rough skin, and cracked lips. Fatigue and lethargy are common, and the

are reports of irregular menses and emotional flareups. Joint pains or bone pains may be noted especially in children.

The effects of vitamin D toxicity are also well known. Current thinking suggests this substance could be classified as a hormone rather than a vitamin. The kidney functions as an endocrine organ in converting prohormone vitamin D to at least one active hormone. There is homeostatic control of metabolism of the active metabolite in the liver, depending on the blood level of vitamin D-3 (cholecalciferol), which is formed in human skin by exposure to the ultraviolet radiation of sunlight. Its metabolism in the kidney depends on blood calcium levels. Early signs of toxicity are weakness, fatigue, lassitude, headache, nausea, vomiting or diarrhea. Finally soft tissue show evidence of calcinosis, while bones become osteoporotic. The kidney is especially affected, with polyuria, polydipsia and pruritus present. In such cases, clinicians suggest not just the discontinuance of the vitamin, but putting the patient on a low-calcium diet and keeping the urine acid.

Vitamin K toxicity generally results from the use of water-soluble synthetic analogues. Such derivatives act as oxidants in the body, causing red blood cell instability and hemolysis.

Is It Natural?

One may ask the question as to whether similar amounts of "natural" vitamins would produce the same effects, since ingestion of such large amounts would have to involve synthetic sources. It is an interesting question that leads to another basic concept that should be appreciated.

The reader is doubtless familiar with the pitfalls of assuming something is "natural" just because the label says so, or because the names of natural substances appear on it. For the benefit of the reader not familiar with the practice, we note the following. A person purchases for himself or a patient "natural rose hips vitamin C" tablets. What could be more natural? The fact is rose hips may contain 0.1% vitamin C, up to 2% by some claims. To get milligrams per tablet up to label specifications, the manufacturer adds plain old synthetic ascorbic acid, the same used in standard pharmaceutical tablets. Otherwise one would have to produce a golf-ball size, or larger tablet depending upon the label milligrams per tablet.

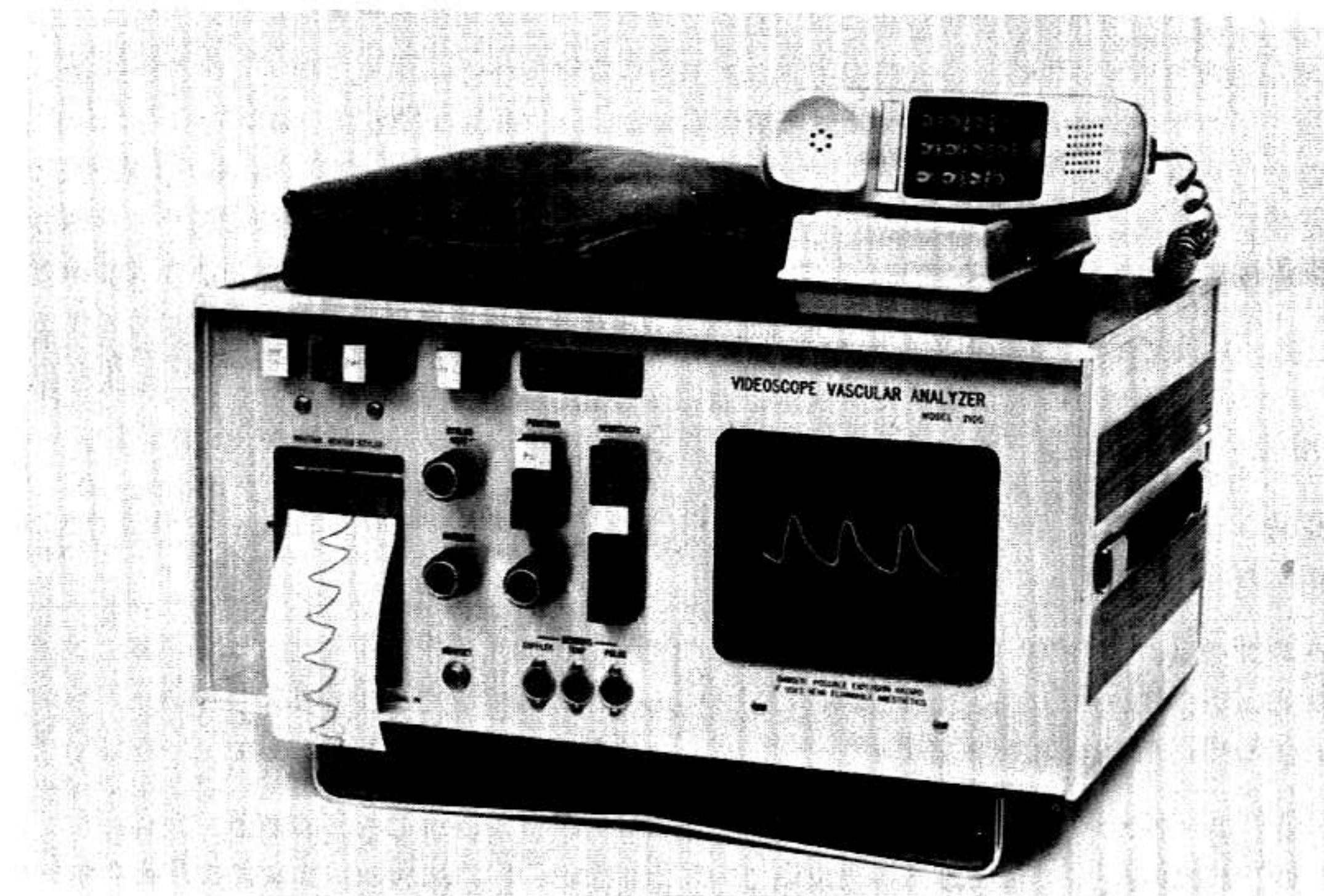
A similar situation exists with regard to vitamin E products. The label or product advertising may loudly proclaim the source for its vitamin E is vegetable oils and is therefore not synthetic. That may be perfectly true. Yet the capsules must be made small enough to swallow. And therein lies the rub. To concentrate the amount necessary for the milligrams or international units per capsule on the label, the manufacturer must use various chemical solvents for extraction and separation. On top of this, the capsule itself may contain a preservative so it will not turn rancid. An additional point: the vegetable material used in such "natural" products may be and usually is grown with the usual chemical fertilizers and pesticides.

A complete discussion of the theoretical implications of synthetic or process-adulterated supplements is beyond the scope or space of this journal. Yet the very possibilities must pose some intriguing questions for the thoughtful reader.

Continues next issue.

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(Continued from page 14)

One leading Eastern medical authority in disc surgery has printed the statement that of all the types of surgery practiced by modern medicine, disc surgery is the most damaging to the patient and the least desirable to be attempted if any other alternative is possible.

A research report conducted in the 1970's showed that 64% of disc herniation surgeries turned out to cause more problems later than the patient had at the time of surgery. With the increasing number of complaints by patients to their surgeons following disc surgery and the corresponding increase in malpractice suits, it is no wonder surgeons are more and more reluctant to conduct this kind of operation.

Most surgeons now insist that the patient sign statements and waivers showing that the surgeon promised no cure and stating that the patient understands the possibility he may be worse following surgery.

Closed reductive disc therapy (CRDT), on the other hand, has almost no complications with its use.

It is not only non-invasive but also is non-forceful. CRDT is completely comfortable throughout the treatment and all pressures that are applied are very gentle, so that no further trauma or adverse stress will be applied to the site of injury.

CRDT is relatively new treatment procedure developed jointly between physicians of the United States, Canada and Europe. It involves placing the patient in a negative gravity position so as to create a negative internal pressure in the disc area. Simultaneously, soft tissue probing designed to return the vertebral disc nucleus into the normal central position of the disc is employed. CRDT involves muscle stimulation with contralateral muscle relaxation.

Finally, reduction of vertebral rotation and tilting, which was primarily responsible for the unilateral hydrostatic stress causing the herniation is accomplished by applying manual dynamic pressure to the site of injury in an exact prescribed manner.

Traction, bracing, physical therapy, exercise, vitamin/mineral supplements, and in some individuals weight reduction, can all be of great value as a supportive or adjunctive regimen.

Statistical data on the effects of CRDT reveal that 83% of the people with disc involvement who receive the form of treatment respond sufficiently to return to their same form of employment. An excellent record, indeed. ☐

EDITORIAL COMMENT

Dr. Wiehe's fine article presents an important responsibility of chiropractic family physicians to provide widely-needed services in an area where orthopedic surgery has been sadly ineffective and grossly overutilized. Publication of these concepts is long overdue and any efforts to suppress them amounts to narrow and futile attempts to stifle the progress and strength of the chiropractic profession. ☐

(Continued from page 20)

Where there are organic lesions of the brain, surgery is indicated.

The patient should be encouraged to live as normal a life as possible, with an adequate social and recreational life.

Members of the epileptic's family must be taught to treat the patient with common sense, and not to be overly solicitous or over-protective. The emphasis should be on the prevention of invalidism.

The chiropractic physician, nutritionist, psychologist or physical therapist's role should be supportive. Each discipline has only a part of the pie — not the entire responsibility.

Supportive manipulation and adjustment should be directed to C7/T1, T 3-4, T 5-6 and T11-12.

Management of a Seizure: Once the seizure begins, there is little to do but support the patient, and prevent injury. The seizure will run its course.

1. Remain calm. This is the first and greatest commandment.
2. Protect the patient from injury while the seizure is in progress.
3. Discourage possible bystanders from "gawking" or becoming panicky. "He is going to be okay. Everything is under control."
4. Loosen tight or restrictive clothing.
5. Roll up a coat, or other soft object and pillow the patient's head.
6. Get a folded handkerchief or some other soft object between the patient's teeth, being careful not to impair breathing. (He may be a mouth breather.)
7. Once the seizure is past, the patient's consciousness may be clouded for a short while. Protect him during this stage. ☐

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SEPTEMBER, 1980

VOL. 2 NO. 6



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THE CHIROPRACTIC FAMILY PHYSICIAN is published bi-monthly by the Council on Diagnosis and Internal Disorders of the American Chiropractic Association, P.O. Box 1577, Glendale, CA 91206.

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PRESIDENT'S PAGE

E.A. Wilson, D.C., Council President

Another convention has come and gone and after the smoke had cleared I found that I was to have the honor of serving as your president for one more year. We will try to make the coming year even better than the last.

The members of this council know what they want. They recognize the only life is in growth, and grow this profession and its members must. Our members still work on the premise that the nervous system controls function and the goal is to restore and maintain nervous integrity. The members of this council have accepted the responsibilities of a physician, the emergencies, the variable and often inconvenient hours as compared with the fixed hours, freedom from emergencies and the easy life of the technician.

All members are reminded that our effectiveness depends on the individual effort of each member. We need your ideas, criticisms and articles. Your officers and committee members are volunteering their energies and time. The membership can help tremendously by providing input, by volunteering in areas of ability or interest and by talking up the council to colleagues. Our resources are limited and the work is great so all the help you can provide will be gratefully accepted. □

"Correlating Diagnostic Concepts — the Unique Contribution of Chiropractic"

by
Richard H. Tyler, D.C.

In a recent conversation with a colleague an attempt was made to impress me with the paucity of diagnostic instruments we have available to us. This of course is not so. Not only are we taught the skills requisite to the training of any other physician but also those indigenous to the conservative health care to which our profession subscribes. Of course there are pockets of resistance both within and without chiropractic that would restrict the use of some forms of laboratory analysis, but the trend is for the walls of stupidity to crumble and it is therefore necessary for us to be ready to become consummate diagnosticians within each individual's potential.

Just about every conceivable non-invasive diagnostic tool is available for our office. Everything from vascular analyzers and electro acutherapy units to ECGs and PCGs can be had for just the purchase price. What is more important however is the special dimension that we as chiropractic physicians give to diagnosis with structural analysis, reflexology and applied kinesiology.

As with any form of diagnosis it is only viable if it is correlated with some other form of analysis of proven value. An excellent example of this is found when applied kinesiology is combined with laboratory diagnosis. The simple act of muscle testing to determine weakness that might be indicative of organic malfunction and then seeking verification through specific laboratory tests can prove very useful.

Using muscle testing, which seems so natural to our profession as neuromusculoskeletal specialists, a weak iliopsoas muscle would be indicative of a possible renal pathology. This in turn could be correlated with renal function screening tests such as

BUN	Addis Count
Creatinine	Urine Culture
Uric Acid	A/G Ratio
Sodium	Serum Lipids
Potassium	PSP
Chloride	Creatine Clearance

A weakness elicited in the sternal division of the pectoralis major muscle would indicate a possible hepatic problem and may be further determined with

Bilirubin (Direct and Indirect)	Prothrombin Time
Urobilinogen	Cholesterol
BSP	Alkaline Phosphatase
Cephalin-Cholesterol Flocculation	SGO-t
Thymol Turbidity	SGP-T
ICDH	

A thyroid pathology could be indicated by a weakness in the Teres Major or Minor muscles or the Infraspinatus and confirmed with the following —

PBI	T4 (Murphy - Pattee)
Cholesterol	Free Thyroxine
T3	Thyroxine Binding Globulin (TBG)
T4 by Column	

The preceding are just three examples in the use of diverse diagnostic techniques combined to develop a diagnosis of increased dimension. The tools we have are unique and when used in concert with the more commonly applied forms of analysis we develop a clinical harmony which is unique and of which we may be justly proud. □

A TRIBUTE CYNTHIA E. PREISS, D.C.

Dr. Cynthia Preiss is undoubtedly one of the most important and influential physicians in the chiropractic profession. In a relatively few years she has accomplished more than many who have practiced far longer than she has. This is due greatly to the indomitable will of this extraordinary woman.

Within three years after her graduation from the Los Angeles College of Chiropractic, Dr. Preiss was appointed to the California State Board of Chiropractic Examiners. Her presence both as secretary and later the first woman board president is still being felt by the profession. She was fearless in the defense of our inviolate right to practice as qualified physicians. Just reading the directives she would issue on behalf of the board was inspiring. How splendid it would be

(Continued on page 28)

"SOME DIAGNOSTIC CONSIDERATIONS, WITH SPECIAL EMPHASIS ON LABORATORY DIAGNOSIS"

by

Andrew R. Jessen, B.S., D.C.

In recent years there has been a definite trend on the part of many toward a more 'natural' lifestyle. Concomitant with this trend in the manner, way, and places where people live there have been similar trends in many fields. For example, in medicine, there is a trend on the part of the more established medical community toward yet another specialty, the family physician. Then into the fringe area of medicine there are those who have adopted what they consider to be the good features of many types of healing practices, and as a result holistic medicine is now being practiced by many physicians. And we should also recognize that there is a similar trend in chiropractic to adopt other treatment methodologies and include them as a part of the chiropractic armamentarium.

Along with this trend in medicine and in some areas of chiropractic there is a counter movement within the chiropractic profession toward what is considered to be 'pure' chiropractic. This movement also has rejected conventional diagnostic methodologies and has more or less confined itself to spinal analysis.

This conflict that is present within the chiropractic profession has resulted in a revolt by some chiropractic educational institutions against the high standards of the C.C.E. Apparently some within the chiropractic profession simply do not care to be burdened with the responsibility as physicians to diagnose their patients. So now, there is a new organization to accredit (?) chiropractic colleges.

And so in view of the foregoing it is well to consider some diagnostic considerations. PRIOR and SILBERSTEIN¹ make this statement, "Accurate diagnosis is now and always will be the keystone of rational treatment." How anyone could fault or argue with that statement I simply fail to comprehend. Perhaps it is as La Rochefoucauld said, "We give advice, but we cannot give the wisdom to profit by it."

And so we shall proceed with some comments on diagnosis.

"We believe that the major objective of a course in physical diagnosis is to acquaint the student with the basic 'tools of his trade', namely, the history, physical examination, and essential medical terminology. In spite of many modern refinements and an increasing number of laboratory procedures, the history and physical examination will remain the cornerstones of the physician's daily work the rest of his life." PRIOR and SILBERSTEIN¹

As conscientious chiropractic physicians we are well aware of the importance of history taking. However, in a busy practice the time factor cannot be ignored. This dilemma is perhaps best described by DeGOWIN and DeGOWIN² in this manner, "Writings on history taking always discuss the extended history, which is complicated and demands maximal skill. But it would be folly to insist on an extended history for every patient; in many conditions, it is unnecessary, the physician could

care for only a few patients in a day. The experienced physician adjusts to the patient's problems. Whether the history is sufficient for the individual case will plague the clinician during his entire professional career." How true that is!

One aspect of history taking that should never be neglected is the simple question, "What medications and or vitamins are you taking at the present time?" The answer to this is oftentimes the solution to the patient's problem. As DeGOWIN and DeGOWIN² state, "In these days of powerful drugs in great variety, the history of drug administration may be diagnostic. Many patients now consult physicians for symptoms that can ultimately be ascribed to excessive medication." As far as the vitamins are concerned, it is not at all uncommon to find that some 'health minded' patients are allergic to yeast and rose hips and other substances used in 'natural' vitamin formulations.

LABORATORY TESTS

In the practice of modern medicine, many physicians consider the laboratory tests to be a, or perhaps the, prime source of information leading to the diagnosis of the patient's condition. As noted beforehand, some in chiropractic object to the responsibility of making a diagnosis, and do not recognize the need for laboratory diagnosis.

However, if you, as a chiropractic physician, choose to utilize, and are legally practicing in a state where you are permitted to utilize laboratory facilities, and here I am referring primarily to blood and urine testing, you most certainly should be aware of the limitations of such test results.

Such limitations are not restricted solely to blood and urine analysis. As an example, DeGOWIN and DeGOWIN² observe, "But the science of pathology has its uncertainties; some lesions of the thyroid gland cannot be characterized as surely carcinomatous without prolonged observation of the patient; sections of an enlarged lymph node in other diseases may collect a series of contradictory diagnoses when sent to several pathologists."

At the present time laboratory blood tests are in general subject to a great deal of error.

In 1970, INGRAM and PRESTON³ reported as follows, "Every day more than a million visual examinations of blood smears are performed in hospitals in the U.S. The routine microscopic blood inspection that is a universal feature of present medical practice is generally depended on as one of the most useful indicators of the state of person's health. Its value lies in the fact that the body's production of the various types of blood cells is highly sensitive to general stress, injuries, diseases (infections or non infections), poisons, ionizing radiations and other noxious stimuli. By increasing the rate of loss of or the demand for specific white blood cells, these stimuli cause the blood-cell-forming tissues to alter their production rate accordingly. The relative number of a particular type of white cell therefore becomes significant. In addition, as may happen in any production line, the change in the rate of output of the cells increases the probability that some of the products will be abnormal. The form of the blood cells tends to reflect, often very sensitively, the conditions under which they were produced. Consequently information about the cells' morphology may be as important as the numerical counts of the various cell types."

"The visual examination of blood cells in present practice is carried out by toilsome human labor. Professional personnel or technicians prepare each specimen as a thin film of blood, then stain it and examine it through a microscope. The method is expensive (the daily cost in the nation's hospitals totals several million dollars and hundreds of thousands of man hours) and often unreliable. In a recent study conducted by the Center for Disease Control it was found that, even in routine classifications of blood cells in normal specimens, the performance was unsatisfactory in 40 percent of the laboratories tested. The results were even poorer when the blood samples represented certain commonly encountered abnormal conditions. As the work load of busy laboratories increases and more of the examinations are relegated to relatively unskilled technical personnel, the rate of error can be expected to rise."

Obviously, the above statement refers to the microscopic examination of red and white blood cells and the white blood cell differential count. If such examinations are "unsatisfactory in 40 percent of the laboratories tested," indeed, a severe problem exists.

It is true that computerized testing procedure for certain biochemical factors in the blood may have been developed. And certain specific tests in themselves may be more accurate. However, the overall results may in themselves be of no great value because of the basic inadequacy or inherent faults of the tests themselves. To illustrate, FORSHAM⁴ in his discussion of The Adrenals states, "The detection of clinical adrenal cortical insufficiency in its incipient state presents a difficult differential diagnostic problem." "Adrenocortical deficiency does not become chemically manifest until nine-tenths of the adrenocortical tissue has been made unresponsive as a consequence of tissue destruction or involution." And all this while the routine laboratory tests for cortisol in blood plasma or urine are normal!

WELLS⁵ states concerning the liver, "It is customary to begin a discussion of this subject with a statement concerning the inadequacy of all liver function tests. It is doubtful, however, whether tests in this group are any worse than others we use from day to day . . . Like other laboratory methods, liver function tests are subject to biologic variation and technical error. Also, the liver is an exceedingly complex organ about which much is known, but little truly understood. The rationale of many tests, particularly those that relate to metabolic or hepatocellular function, cannot be clearly defined. In reference to tests and clinical observations, the liver appears to have a great functional reserve, so that 80 or 90 per cent of the organ may be destroyed before an abnormality can be detected" . . . "Since all known liver function tests are too insensitive to detect early, mild or localized lesions, they should be used chiefly when there is clinical evidence of liver disease or in the presence of conditions known to be associated with disorders of the liver and biliary passages. In other words, liver function tests have little value as part of a general diagnostic survey."

Concerning the excessive use of laboratory tests, BOYCE⁶ makes the following comment, "There would be no particular profit in trying to estimate how many of the laboratory tests performed today are unnecessary. It is enough to say that a great many of them are open to this charge."

Because of the obvious shortcomings of the presently available liver function tests and a growing exposure by the general public to toxic substances in the environment, some physicians in many cases, especially to work environment, some physicians have exhibited a grave concern at this dilemma. As a result some are searching for new liver function tests which would disclose liver function abnormalities in early or incipient stages. Some highlights from a paper by HERRMANN⁷ may help us to better understand this dilemma and appreciate his concern. "The incidence of liver disease has progressively increased in countries with a high standard of living. According to the latest World Health Organization statistics 34.2 persons per 100,000 died of liver cirrhosis in France whereas the mortality rate in Iceland amounted to 2.1 only. In the United States of America liver cirrhosis is, according to Popper, the fourth most frequent cause of death among people over 40 years of age."

"Studies have shown that, independent of the type of damaging factor, either virus, bacterial, or toxic, the pathological changes in the liver cell develop organo-specifically, that is, the liver cell always responds to the various kinds of damage in the same way." In his paper he points out the relationship between obesity and liver damage. "On correlating overweight, liver diseases and professional activity, it was apparent that overweight and stress at work may lead to an increased susceptibility to liver damage."

Herrmann's paper was originally published in "The Medical Bulletin" of the Standard Oil Co. of New Jersey. His concluding paragraph gives pause for thought. "A medical programme in industry should include careful evaluation of liver function. This is particularly important in view of the increasing abuse of alcohol and the extensive use of chemical substances which are known to exert toxic influences on the liver tissues. Only a well conceived programme will prevent a transition from subacute liver diseases to mesenchymal reactions and finally to an irreparable cirrhosis which, if not detected in time, will considerably reduce the life expectancy of the patient. Not until then will it be possible to reduce the alarming figure of undetected cases of liver cirrhosis which were recorded by a large Berlin clinic on comparison with autopsy findings, of 544 cases of true cirrhosis, 55.4 per cent had not been detected clinically until autopsy."

It is all too easy, when all physical, x-ray and laboratory findings are 'normal' to begin to think that the patient is a mental case. For any who have this tendency, the following comment by BOYCE⁶ is food for thought. "Certainly the surgical resident should consider it to be one of his prime responsibilities to attend every postmortem examination conducted while he is not engaged in other duties that cannot be postponed. Few medical exercises are more instructive or more conducive to avoidance of future errors and accuracy of future diagnosis and treatment. There are also few occasions that may furnish more striking surprises and that may deal greater blows to one's complacency than to see a diagnosis made on the basis of an apparently classic clinical picture turn out, indisputably, to be something different. Many years ago Lord Moynihan pointed out the lessening number of functional diseases brought about by demonstration at postmortem that they were actually dependent upon changes in structure. His warning should be remembered now, when emphasis upon the possibilities of psychomatic medicine has real elements of danger."

BOYD⁸ in discussing the use of tests to determine the status of the liver quotes from Hinsworth who stated, "There is yet no test which approaches in value a careful clinical examination of the patient."

VAN WAGONER⁹ stated, "I have found, at least among my own patients, that perhaps malfunction of the liver is one of the most common abnormalities."

We should divest ourselves of some of the past concepts we may have concerning the rate of progress of some diseases. It has classically been taught, and understood that liver disease is a long term situation, progressing from fatty degeneration to enlargement and eventually to cirrhosis. ZENZ and BYERRUM¹⁰ report, "Rabbits exposed to very pure vanadium pentoxide dust at 205 mg/cubic meter, with nearly all the particles below 10 microns in diameter, died in 7 hr. Tracheitis was very marked, and there was bronchopneumonia with pulmonary edema. In addition, conjunctivitis, enteritis, and fatty degeneration of the liver were noted." Fatty degeneration of the liver in just seven hours! How long did you think it took?

The problems inherent with the use of the laboratory for diagnosis of human disease is simply not eliminated when one uses other diagnostic methodologies. For example, let us briefly consider radiographic studies.

RADIOGRAPHIC STUDIES

As we all well know, the use of the x-ray for diagnostic purposes has many advantages, for certain conditions. One of the big problems is of course attempting to determine soft tissue changes. Lung cancer is a prime example, by the time it is detectable on the x-ray films it is frequently too late.

In a recent article in the National Geographic, BORAICO¹¹ interviewed Jack A. Vennes, M.D., at the University of Minnesota with regard to the use of endoscopic examinations with the use of the endoscope which is a fiber-optic device. "Subtle hues of color mean nothing to an x-ray," Dr. Vennes said, "and lesions this small (diameter of a pencil eraser) may go undetected; X-rays miss more than a quarter of all stomach ulcers, for example. With endoscopes, on the other hand, you catch nearly everything."

STATISTICS AND DIAGNOSIS

In the age of the computer and double blind studies and the irritatingly smug position taken by some 'scientists' to anything new that has not been 'proven', it is quite interesting to take a little look at some of the ways in which numbers find their way into the computer. Many of the things that are 'accepted' are really resting on a pretty sandy foundation.

Just what are the sources of those hallowed laboratory normals? COPELAND¹² reports, "Two convenient normal population groups are: (1) blood bank donors, and (2) persons who are working and feel healthy. Our true knowledge of normal values is still very limited. It is known that, because of many unknown variables, normal values from the literature cannot be assumed to be valid for any individual laboratory unless checked." It's comforting to know that the winos and perverts of skidrows throughout the country are the source of laboratory normals!

Commenting on the ability of laboratory procedures to guarantee reliable measurements, COPELAND¹² reports, "First, no method of analysis gives exactly the same result each time it is repeated. There is an inherent variability characteristic of each measurement procedure that cannot be avoided."

With respect to the diagnosis, DeGOWIN and DeGOWIN² make some most interesting observations. "Diagnoses in many diseases, particularly in internal medicine, have a greater degree of uncertainty which may or may not be resolved by an autopsy many years later. Occasionally a therapeutic test is warranted, and the diagnosis is based on the results; the interpretation of such tests is frequently difficult and equivocal.

"But, in the production of medical records, conclusions with all degrees of certainty tend to be labeled as *the diagnosis*, without qualification. The coding of diagnoses in hospital record rooms tends to force dogmatism and leaves little room for qualification. Furthermore, a question mark before a recorded diagnosis, or the word "probable", is often ignored or dropped when another physician subsequently interprets the record. The hedging reports of the pathologist meet with the same fate.

"In the medical record of the patient during prolonged observation of the disease, some distinction is usually made to indicate the degree of certainty at various stages. In the initial record of the history and physical examination, the physician frequently appends a list of diseases to be considered and labels one with a term such as preliminary diagnosis, diagnostic impression, tentative diagnosis, working diagnosis, provisional diagnosis, or probable diagnosis. After the studies have been completed, however, the official statement reads the diagnosis or final diagnosis without much qualification.

"Frequently several final diagnoses are listed for more or less unrelated diseases found during the course of the examination. Some hospitals insist that one of the list be labeled primary diagnosis and the remainder secondary diagnoses. The primary diagnosis is then coded on punch cards or fed into a computer, to the complete satisfaction of the statisticians! They would be most confused to learn that the selection of primary diagnosis from their list would vary widely when submitted to an internist, a surgeon, an otolaryngologist, and an orthopedist; each would insist that the item from his specialty was primary. The question is, then, primary diagnosis for whom?"

Now, with the foregoing in mind, just how valuable are all of the fancy double blind studies? When the great margin of error that exists in making an accurate diagnosis of the patient's true condition is recognized as it truly is, just how valid are the numbers that come out of the computers?

As an example, the latest issue of the ACA Journal, the March 1980 issue, contains an article that originally was published in the Journal of the AMA, by SIMON et al.¹³ Basically the article was, "An Evaluation of Iridology," and the study was very well presented as far as the statistical evidence is concerned. An attempt was made to evaluate the ability of some well known iridologists, including at least two well known chiropractors who have practiced this method of diagnosis for many years. The conclusions? "The results of this study show that there is no value in iridology as a screening technique for detecting or diagnosing kidney disease."

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NUTRITION FOR THE WHOLE PERSON

From APPLIED TROPHOLOGY

Vol. 22-No. 3 — 3rd Quarter, 1979

(Continued from July issue)

Editorial Statement:

This article is published with the kind permission of Standard Process Laboratories, Inc. and the author Norman Swift. It provides a reasonable presentation of a currently controversial subject. The Chiropractic Family Physician takes no position which could be construed to in any way restrict the freedom of the chiropractic physician to use nutritional substances that may benefit his patients. We appreciate the opportunity to make this information available to our readers.

Effects of Excessive Water-soluble Vitamins

It is a mistake to assume the water-soluble vitamins can produce no side effects because they are not stored in the body. Adverse effects may be common, although not always recognized as such. Let us take a few examples to make the point.

Niacin (nicotinic acid) is currently being employed in megadosages for schizophrenia and other ailments. Aside from the obvious effect of flushing or vasodilatation, there are also reports of its causing tachycardia, fainting, hyperglycemia, skin rashes, itching, nausea, ulcer activation and disturbed liver function, just to list a few such conditions. The medical profession has also used niacin to lower serum cholesterol and to prevent myocardial infarction. A well controlled study was set up on a national level, the Coronary Drug Project. The results were published in a major journal of that profession (JAMA 231:360-381, 1975). The conclusion? Taking megadoses of niacin to lower serum lipid levels had no effect on preventing heart attack. Interestingly, there was a greater incidence of cardiac arrhythmias in the niacin-treated group as compared with the placebo group.

Let us not lose sight of a fascinating point: as do certain drugs, megadoses of niacin may indeed lower serum lipids. The question is, is this good, is it desirable? If at the same time serum lipids are merely driven into the tissues, such action is certainly not desirable. A figure on a blood test may appear to be within so-called normal limits, but what is the net effect to the person? Again, the human organism must be looked at as a complex whole. One must beware the pitfall of looking for even the "natural" agent that will reduce serum A or rise the level of serum B, without considering the possible far-reaching effects on, say, serum C or D — not to mention enzyme systems X, Y and Z.

Pyridoxine, vitamin B-6, was once thought incapable of producing side effects. Evidence now indicates it is capable of producing liver disturbances, adding to earlier reports of convulsive disorders in children from pyridoxine excess. Even this surface scratching will doubtless cause the reader to pause before thinking that the B vitamins are incapable of producing adverse effects.

(Continued on page 14)



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(Continued from page 12)

Again, it should be noted that vitamin B products are often formulated in similar fashion to what we have considered relative to vitamins C and E. That is to say their "natural" composition must be open to question. Synthetic products are often added to natural bases in order to bring milligrams per tablet to higher levels. One may also question the source and treatment of the natural base.

Rather than involve ourselves in current controversies over vitamin C, let us again set forth a few simple points. Consider the phenomenon of rebound scurvy, which occurs when large dosages of vitamin C are abruptly discontinued. If one is ingesting, say, fifty times the amount biologically utilizable, the mechanism for destruction may be operating at fifty times normal. When one stops the megadose, destruction of ascorbic acid continues. Thus rebound scurvy occurs. This may not be dangerous in an adult, but may be serious in the case of a pregnant mother taking in megadoses. Her infant is born with a catabolic mechanism operating to deal with the excess vitamin C from maternal circulation. When the baby goes on its own diet, the results is rebound scurvy. The principle is possibly applicable to overingestion to other vitamins as well.

Megadoses of vitamin C have precipitated gout in patients with high serum uric acid levels. Such doses have untoward effects on bone metabolism in experimental animals and can lead to increased urinary excretion of oxalate in humans, with the danger of renal stone formation. Megadosage has activated hemolytic anemia in predisposed subjects, such as ethnic groups with glucose-6-phosphate dehydrogenase (G6PD) deficiency.

This is not to suggest that larger-than-physiologic doses may not have an effect on such entities as the common cold, the infectious processes, and so on. It merely serves to illustrate the basic concept presented in this issue: megadosages serve chemical rather than pure vitamin functions and this must be recognized for what it is. Some such chemical functions may be desirable; others may be detrimental or obscure the underlying problems of the patient. It is also reasonable to conclude there may be far-reaching unwanted metabolic effects that are as yet unknown.

Potency — A Valid Concept?

In view of this line of reasoning, it seems sheer folly to look for the label with the highest milligrams or the most ingredients per tablet. As a matter of fact, one has to challenge the usage of the term "potency" in this connection. One cannot accurately refer to an item with lower milligrams per tablet of a substance as being lower in potency than something with a higher figure on the label. It is clear that more is involved. According to Webster, potency refers to the ability or capacity to bring about a particular result. Thus, if a substance or combination of substances has the ability or capacity to bring about a desired result, that substance or combination is potent.

It is noted with some sadness that young physicians fresh out of even nonmedical schools will ask supplement manufacturers or suppliers for the highest potency product, with — and note the expression — "pharmacological" dosages. In the case of the chiropractic or naturopathic physician, this denies their professions' rich heritage of attempting to care for the human organism without pharmacology. One

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can only hope such expressions are mere slips of the tongue, and that the seeker of his patient's health is really looking for a physiological effect. Maimonides' wise advice echoes through the centuries: "The physician should not treat the disease but the patient who is suffering from it."

Illustrative Thoughts on Zinc and Copper

In the last few years there have been numerous articles published even in conservative medical journals relative to the use of zinc in wound healing, hypogeusia (diminished capacity of taste), sexual maturity, skin lesions, and so on.

An editorial in **The Lancet** (January 28, 1978) called attention to yet another aspect of zinc metabolism, under the heading "A Radical Approach to Zinc." It stated: "In enzymology zinc already has a venerable past. Carbonic anhydrase, a zinc-protein, was the first metalloenzyme to be identified; and the score of zinc enzymes is now over eighty. Their functions are so varied that they defy categorising: no metabolic pathway of any importance, from alcohol detoxication (sic) to nucleoprotein synthesis, could exist without them. It is now suggested that, in addition to these varied enzymic roles, zinc also intervenes in non-enzymic, free-radical reactions — in particular, that it protects against iron-catalysed free-radical damage . . . Iron-catalysed free-radical oxidation is known to be inhibited by other trace-metal complexes (notably by ceruloplasmin), by metalloenzymes (catalase, peroxidases, superoxide dismutases), and by free-radical scavenging antioxidants (vitamin E)." (Incidentally, superoxide dismutase is a zinc-manganese metallo-enzyme, just one of many such). A magic bullet?

The journal observes the first human disease specifically attributed to zinc deficiency was acrodermatitis enteropathica, an inborn metabolic disorder. It notes the possible relevancy of the disorder's affecting a tissue most continuously exposed to ultraviolet radiation, the skin. Noting that very little can be taken for granted with either trace elements or free radicals, the editorial continues: "In the same speculative vein one may note that of all human organs it is the eye which has the highest zinc content; and that seminal fluid, the body fluid with the highest zinc concentration, is the only one in which cells must survive outside the body if they are to fulfill their physiological function. Zinc may prove to be rather less prominent in protecting against iron-catalysed free-radical damage than has been suggested, but if the suggestion catalyses a 'radical' approach . . . it will have served a useful purpose."

Earlier this year the conservative **Journal of the American Medical Association** published a report entitled "Evidence of Copper and Zinc Deficiencies." Using atomic absorption spectrometry, researchers measured copper and zinc intake in hospital patients and made comparisons of twenty diets made from conventional foods. They concluded that hospital and American diets in general seem to be low in copper and zinc "in comparison with current estimates of the respective requirements." (JAMA 241:1916-1918) Some theoretical implications concluded the report. "Natural and controlled experiments with animals can serve as guides in a search for human disorders. Among the more important abnormalities in animals produced by copper deficiency are (1) anemias, (2) defects in connective tissue leading to abnormalities of arteries and bone, (3) degeneration of brain and spinal

cord secondary to abnormal myelinization, and (4) myocardial degeneration. Zinc deficiency has produced (1) growth impairment and delayed maturity, (2) skin lesions, and (3) reproductive failure and fetal abnormalities. If diets in the United States frequently contain too little copper or zinc, some of the consequences must be common." Ironically, many current texts flatly state copper deficiency is unknown or impossible.

Our point, however: without careful thought, the unwary physician could start assuming a magic bullet has been found. He might routinely suggest a copper supplement or a zinc supplement for all his patients. He could fall into the trap of looking for a product with the highest potency. Yet uncomplicated deficiencies of single nutrients are usually not found in humans. Once again, one must look at the patient as a whole. The old adage could apply, "A little knowledge is a dangerous thing."

Sure enough, reports are coming in of side effects following zealous but indiscriminate administration of zinc. Interestingly, zinc is known to produce copper deficiency in experimental animals. Reports have been published of hypocupremia, lowered serum copper levels, produced by administration of zinc. High plasma copper levels with low plasma zinc levels have been reported in zinc-deficient dwarfs from the Middle East and in sickle cell anemia. Thus some researchers suggest a reciprocal relationship between zinc and copper. Both elements may compete for similar binding sites in the tissues.

According to reports by other researchers, a high ratio of zinc to copper in the body may be the basis by which most of the known risk factors for coronary heart disease exert their influence. High concentrations of zinc (or copper deficiency) have been shown to produce connective tissue abnormalities in the blood vessels of experimental animals. Cirrhosis, apparently protective against coronary heart disease, is reportedly associated with a decreased zinc-copper ratio in the liver.

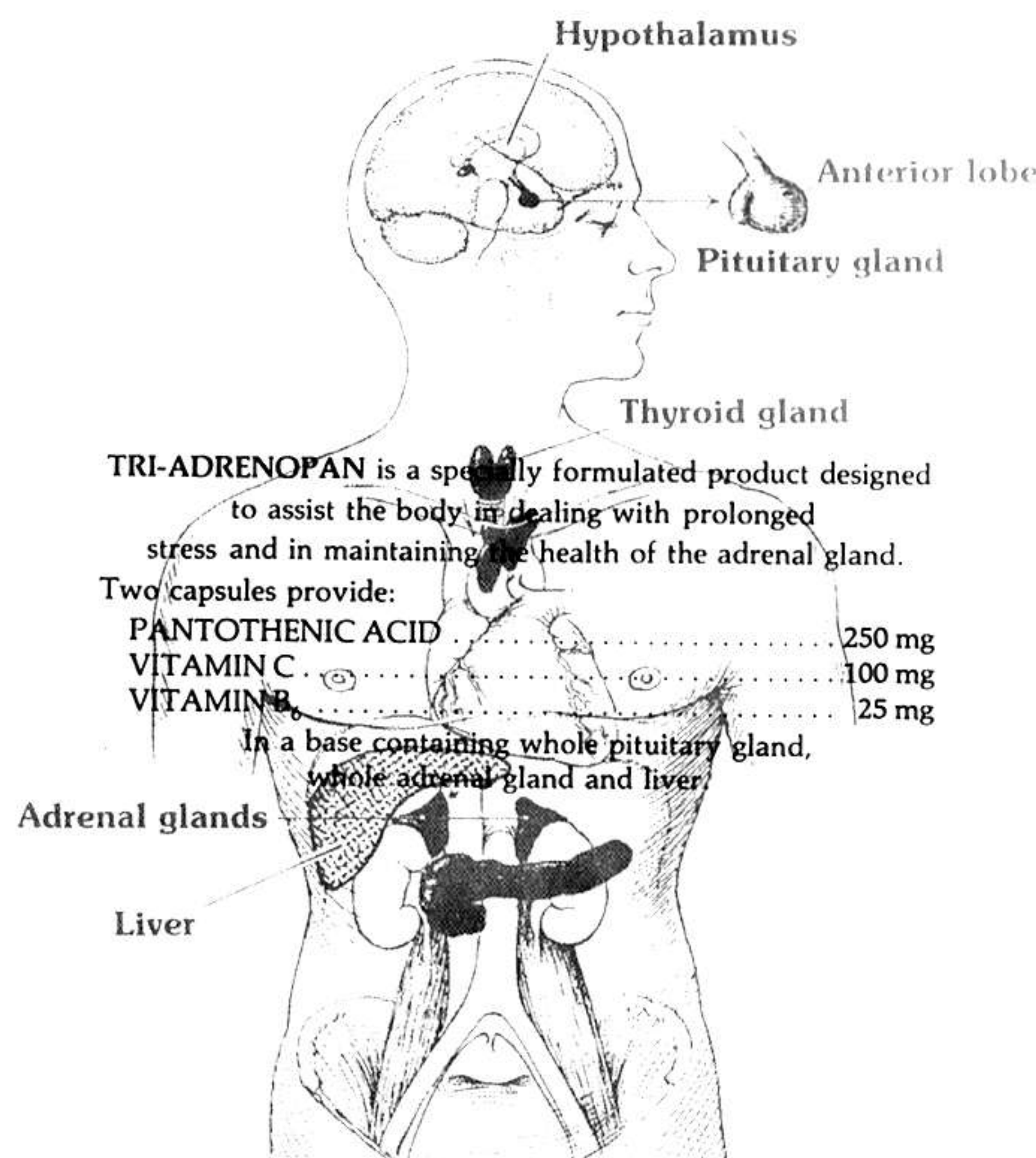
These facts could either be foolishly ignored or be wisely put to a useful purpose. As an example, the relationship between zinc and copper in humans may suggest that zinc could be beneficial to persons with hepatolenticular degeneration or other conditions associated with the toxic effects of too much copper. It can easily be seen that zinc supplementation by itself, without carefully considering all factors, may produce a number of unwanted effects, however.

Protein Problems

A final example of the hazards of not putting all the facts into perspective and applying them: the ill-fated liquid protein diet fad. No one can successfully argue about the need for protein. Proponents of the diet reasoned that if carbohydrate is restricted, then the body must burn up its stores of fat for fuel. Readers are doubtless familiar with the media-publicized furor over this diet. We wish only to take note of an interesting point of physiology. How do researchers produce severe magnesium deficiency in the animal model? High protein diets are used. The resultant magnesium deficiency produces an inevitable loss of potassium not correctable by administration of potassium alone. Also produced is cardiac myopathy charac-

(Continued on page 19)

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(Continued from page 17)

terized by myocardial cell necrosis. Even with vitamin and mineral supplements (excluding magnesium, of course), rats on such a diet die by cardiac arrhythmia or grand mal seizure after ten to fourteen days. Again, there is no magic bullet.

Space does not permit a detailed discussion of theoretical or real problems associated with the administration of large or unbalanced amounts of vitamins, minerals and related substances. It may require a little digging, but such information is available in current texts, published literature and even careful clinical observation. Some basic thoughts should stand out clearly from this discussion, however.

Conclusions

- (1) Megadoses of vitamins do not serve a vitamin function. Rather, they serve as chemicals. Their effects at the organ, cell and subcellular level must be recognized as such.
- (2) "Potency" cannot be established by comparing milligrams per tablet as a criterion.
- (3) Aside from the question of synthetic versus natural, the whole concept of what is "natural" is open to question.
- (4) The thoughtful physician must be cautious about looking for the quick, single or simple answer to the patient's apparent problem. He must wisely look to the organism as a complex whole.

In 1877 the English biologist Thomas Henry Huxley wrote his treatise, "On Elemental Instruction in Physiology." In it he said: "If a little knowledge is dangerous, where is the man who has so much as to be out of danger?" With the exciting rush of new facts of physiology flowing in daily, the new author of this journal does not presume to be out of danger. Yet as the first-century Latin poet put it, even a dwarf can see far when he stands on the shoulders of giants. □



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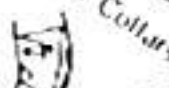
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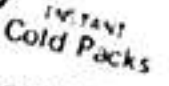
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At this point I should make it perfectly clear that I am not an irisdiagnostician. However, the aforementioned study that essentially 'shoots down' irisdiagnosis used as a standard of evaluation of kidney disease the plasma creatinine level, "as ascertained by the alkaline picrate reaction on dialyzed specimens of serum." In this study, the control group, those patients that were considered as not having any kidney disease, had a plasma creatinine level of from 0.5 to 1.2 mg/dL. And yet, SHAW and BENSON¹⁴ report, "The normal concentration of creatinine in plasma is quite low (around 1 mg per 100 ml.) and the precision of chemical estimation at this level is not good." And further, "Plasma creatine concentration (Pcreat) does not adequately reflect early renal damage. Besides analytical imprecision in its estimation, its value in detecting early functional impairment may be obscured by compensatory increases in creatinine excretion."

One simply cannot measure the diameter of the bore of the cylinders in an automobile engine with a yardstick, it takes an inside micrometer. In like manner, to evaluate one diagnostic method, irisdiagnosis, by the use of an admittedly imprecise "chemical estimation" is hardly conclusive of anything.

COMMENTS

One must be very careful to NOT get trapped into the position of accepting numbers on a laboratory report as being representative of any great degree of accuracy. They simply are not. In this day and age of the computer and the fancy looking computer printouts it is all too easy to rely very heavily on those fancy numbers. They look so official, and so impressive and so scientific!

Consider what some other authorities have to say.

WYNGAARDEN¹⁵ states, "The more information the physician has about his patient, the more effective the physician should be in caring for him. To ensure that this is the result requires a sophisticated knowledge of medical science, excellent clinical judgement, and a profound respect for the limitations of the laboratory. One of the best ways of acquiring the constructively critical attitude so essential to the proper evaluation of laboratory test results is for the student or house officer to work in a laboratory for a while. There is irony in the present pattern of medical education: at a time of unparalleled reliance upon an ever-expanding universe of laboratory tests in the practice of medicine, first-hand learning experiences in the laboratory are being progressively eliminated from the medical curriculum."

And in the conclusion of his paper this same author states, "Laboratory tests are critical to the diagnosis of disease and management of patients. They have both great value and inherent imprecision. The doctor must know the limits of reliability and usefulness of each test result in the clinical setting of the individual patient. This is particularly true when all deviant test results have returned to normal but the patient is not improving. It is especially when the laboratory data provide little or no help that the patient needs a doctor."

And, if the above is not convincing to some, consider this as related by HOFFMAN¹⁶ considering Alton Ochsner, a surgeon, who trained the famous heart surgeon Michael De Bakey. Dr. Ochsner is over 82 years old. "The trend in American medicine, as in American life, toward trying to get by with mere competence while

(Continued on page 23)

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REFERENCES:

- ¹ Graham, D.Y., Enzyme replacement therapy of exocrine pancreatic insufficiency in man, N. Engl. J. Med., 296, 1314 (1977).
- ² Bland, Jeffrey, Glandular-Based Food Supplements: Helping to Separate Fact From Fiction 1979-80. (1980).
- ³ DiMaggio, E.P., Comparative Effects of Antacids, Cimetidine and Enteric Coating on the Therapeutic Response to Oral Enzymes in Severe Pancreatic Insufficiency, N. Engl. J. Med., 297, 854-858 (October 20), 1977.
- ⁴ Gyr, K., Felsenfeld, O., and Zimmerli-Ning, M., The Effect of oral pancreatic enzymes on the intestinal flora of protein deficient Vervet monkeys challenged with *Vibrio cholerae*, Am. J. Clin. Nutr., 32, 1592 (1979).

LETTERS TO THE EDITOR

Dear Dr. Nelson:

Enclosed please find my check and application for the Council.

If your year starts in July of 80, please enter me at that time.

May I also add I was attracted to the CDID by your generous mailing of the Chiropractic Family Physician.

I hope to become an active member.

Kindest Regards,
Harvey E. DesChamps, D.C.D.
Hancock, Maryland

WARNING!

Some doctors move and forget to send us their new address so they stop getting their Chiropractic Family Physician which is still going to their old address. When you move be sure to send us both your **old** and **new** address. Our mailing card files are listed by ZIP CODE — without your old ZIP number we cannot find your card. □

Clinical Roundtable A CASE OF PCP (Phencyclidine)

by
Ralph J. Martin, D.C.

We have current problems in our society which call for better solutions, if they can be found, than are being applied, too often with very poor results.

Only a week ago one of my patients brought in her four year old son because he was having convulsions, fever, and irrational and weird behavior which was completely out of character. They had taken him to their pediatrician who had done a number of tests. They were horrified when the urine showed PCP and as it had to be reported to the police the narcotics agents came in to investigate the origin of the toxic substance.

There was a house close by the patient's home that had been fumigated several days before. Older children were questioned and they reported that our four-year-old and other small children had been playing around that house and had been seen picking up cigarette butts and putting them in their mouths. The agents located the man who had been in charge of the job and he admitted that one of the three men who were on that job was an addict. They presumed that he must have soaked the cigarettes in the PCP or put the powder in the cigarettes he was smoking and thus at least one child had picked up one that had the toxic substance and absorbed it through his mouth.

Diagnosis: This information was not given to me at first, only that the child had been having convulsions and fever and behaving very strangely. Starting with this I set about finding out the cause of the symptoms with the Ohm meter and continued

(Continued on page 29)

(Continued from page 20)

not striving for excellence, worries Ochsner. "The other thing that worries me is that physicians rely too heavily on laboratory findings. I fear we are developing a group of competent technicians, treating disease but not treating the whole patient. I stress to our young people that they must sit down with a patient, take a complete history, do a careful examination, then evaluate the findings and arrive at a working diagnosis. AFTER that, they should order laboratory tests. If the laboratory work confirms the clinical diagnosis, accept it. If it doesn't, disregard the laboratory findings and keep on looking. Sounds like heresy, I know, but it's true." And further, "Doctors MUST LISTEN to the patient, discard their hidebound preconceptions, track down every clue, have the courage of their convictions even when their peers oppose them. I can't emphasize this enough to students."

From the foregoing it is quite clear that too great a reliance on laboratory diagnosis can oftentimes result in a wrong diagnosis. To be a good clinician one simply has to know the history and course of the various diseases and to be able to spend sufficient time eliciting a history from the patient to arrive at a working diagnosis. Because learning about all of the diseases is indeed a monumental task many practitioners take the easy way out, they seek shortcuts to a diagnosis. They let the laboratory and the X-ray laboratory reports be the basis for their particular diagnosis. Or perhaps they seek other diagnostic methods such as:

1. Irisdiagnosis
2. Kinesiology and muscle testing
3. Acupuncture or acupressure meridian points
4. Neurovascular points
5. Neurolymphatic points
6. Sacro Occipital Technique with occipital fiber and trapezius analysis techniques
7. Reflexology with various mapping for:
 - A. Ears
 - B. Feet
 - C. Hands
 - D. Colon

Quite obviously there has been a prolific number of various methods and techniques developed in order to essentially circumvent traditional diagnostic methodologies. A number of questions arise. Has this been because of a strong belief in those personalities that have presented these various techniques? Has it been because of the desire to be able to make a 'diagnosis' in a minute or two? Has it been because of a desire to diagnosis by any method other than conventional? To have something different and special with a certain mystique to impress the patients? Obviously there could be many reasons why one particular method appeals to a certain practitioner and another method appeals to another practitioner. As a result, there is, within the chiropractic profession a veritable multitude of quite different techniques. And, it should be noted, that many of these techniques do indeed involve various types of diagnostic methodologies other than conventional. At times it is indeed all too easy to use the conventional diagnostic methods as a "safe shelter" and to become somewhat critical of those who do not use conventional diagnostic means. However, as this article has attempted to show, just what is the track record of the conventional method? Not really that great.

And so what does one do? Simply pick out the method of diagnosis and treatment that appeals to one's instinct? There has to be a better way.

It would seem that it is somewhat premature to be overly critical of any diagnostic method that 'works'. In this respect, it is certainly easier to understand the reasons, and even some of the thinking behind the adamant stand taken by some in chiropractic that stick pretty close to the spine. There is going to have to be a lot of progress in the accuracy and the utilization of the present day laboratory methods before they can be used as a standard by which to judge other diagnostic methodologies.

In the meantime, to utilize the pattern of symptoms, to the spinal nerves involved, and to the vertebral level involved is a pretty hard combination to beat. We need to become simply excellent clinical neurologists in order to become excellent clinical diagnosticians. As ELLIOTT¹⁷ so succinctly states, "Emphasis on the value of clinical methods is needed at a time when radiological and laboratory procedures are all too often misused as a shortcut to diagnosis."

In reality, there simply are no diagnostic shortcuts. History reveals this quite plainly. During the 1930's there were an excessive number of appendectomies performed. During the 1970's, hypoglycemia was a very popular diagnosis. It is quite obvious that there have been very definite phases during which one particular diagnostic entity was popular. It is so very easy to go along with the crowd. The historical fact of these past phases of various and sundry popular diagnoses most certainly is a telling factor that to really make a correct diagnosis is obviously not a simple matter. One needs all the information that can be obtained, without going overboard in the matter of special testing. And again, here is where an adequate history and examination, and a thorough knowledge of the various diseases, and their courses in the human body are quite simply mandatory.

Let us all hope that when laboratory tests are utilized as part of the methodology to evaluate the efficacy of chiropractic in research studies that a yardstick is not used when a micrometer is indicated!

REFERENCES

1. Prior, John A., Silberstein, Jack S.: *Physical Diagnosis*, Second Edition, Saint Louis, The C.V. Mosby Co., 1963, p. 21, 9.
2. DeGowin, E.L., DeGowin, R.L.: *Bedside Diagnostic Examination*, Second Edition, New York, The Macmillan Co., 1969, p. 12, 20, 5, 6.
3. Ingram, M., Preston, Kendall Jr.: "Automatic Analysis of Blood Cells", *Scientific American*, Vol. 223, No. 5, Nov. 1970, p. 72-82.
4. Forsham, Peter H.: "The Adrenals" in *Textbook of Endocrinology* by Williams, Third Edition, Philadelphia, W.B. Saunders Co., 1962, p. 319.
5. Wells, Benjamin B.: *Clinical Pathology*, Third Edition, Philadelphia, W.B. Saunders Co., 1962, p. 165, 166.
6. Boyce, Frederick F.: "The Surgical Resident" in *Christopher's Minor Surgery* by Ochsner and DeBakey, Eighth Edition, Philadelphia, W.B. Saunders Co., 1959, p. 86, 83.
7. Herrmann, Hellmut: "The Early Diagnosis of Asymptomatic Liver Disease Within an Occupational Health Programme", *Industrial Medicine*, Vol. 41, No. 3, March 1972, p. 31-33.
8. Boyd, William: *A Textbook of Pathology*, Seventh Edition, Philadelphia, Lea and Febiger, 1961, p. 786.
9. VanWagoner, Mark B.: "Clinical Laboratory Study of the Liver", *The Digest of Chiropractic Economics*, Vol. 15, No. 3, Nov.-Dec. 1972, p. 10-12.

10. Zenz, Carl, Byerrum, Richard U.: "Biologic Effects of Vanadium" in *Vanadium* by Committee on Biologic Effects of Atmospheric Pollutants, Division of Medical Sciences, National Research Council, National Academy of Sciences, Washington, D.C., 1974, p. 60-61.
11. Boraiko, Allen A.: "Harnessing Light by a Thread", *National Geographic*, Vol. 156, No. 4, October 1979, p. 516-534.
12. Copeland, Bradley E.: "Statistical Tools in Clinical Pathology" in *Todd-Sanford Clinical Diagnosis by Laboratory Methods*, 15th edition, edited by Davidsohn and Henry, Philadelphia, W.B. Saunders Co., 1974, p. 2, 3.
13. Simon, Allie, Worthen, David M. Mitas, John A.: "An Evaluation of Iridology", *ACA Journal of Chiropractic*, Vol. 17, No. 3, March 1980, p. 29-34.
14. Shaw, S. Thomas, Jr., Benson, Ellis S.: "Renal Function and Its Evaluation" in *Todd-Sanford Clinical Diagnosis by Laboratory Methods*, 15th edition, edited by Davidsohn and Henry, Philadelphia, W.B. Saunders Co. 1974, p. 89, 96.
15. Wyngaarden, James B.: "The Use and Interpretation of Laboratory-Derived Data" in *Textbook of Medicine*, 14th edition, edited by Beeson and McDermott, Philadelphia, W.B. Saunders Co., 1975, p. 1880-1883.
16. Hoffman, Nancy Yates: "Alton Ochsner: 82 and still going strong", *Executive Health* (Rancho Santa Fe, California), Vol. XV, No. 12, September 1979.
17. Elliott, Frank A.: *Clinical Neurology*, Second Edition, Philadelphia, W.B. Saunders Co., 1971, p. vii. □

BOOK REVIEW

"The Journal of Energy Medicine"

This is the first time I have departed from our policy of reviewing a specific volume in favor of reviewing a quarterly publication. I felt however that the magazine was of sufficient importance to be reviewed as a single entity.

For years the healing arts have been divided and fighting among themselves. This had damaged not only those who practice but also those who are practiced upon. When the doctor cannot help his patient all too often he will remark the "everything possible has been done." This should be qualified by simply adding . . . "that I am qualified to perform." Ego being what it is within all of us makes it difficult for the doctor to recognize and then to admit, that he indeed is not a therapeutic panacea and what is more important that his particular health discipline is not the answer to all of man's ills.

At last a publication of superior design, quality and conceptualization has been produced to promulgate the holistic and eclectic approach to man and his ability to survive the slings and arrows of outrageous disease.

Issue number one begins with an editorial statement which is refreshing and intellectually stimulating. This is followed by a section entitled "A Multidisciplinary View of Herpes Simplex II" Beginning with a description of the pathology and the more conventional medical therapeutic approaches the section progresses with portions authored by an M.D., an R.N., and nutritionist, a D.C., a homeopath, an acupuncturist and more. Each gives his concept of treating the same pathology. This just sets the tone for what is to follow.

Of particular interest are the papers authored by the chiropractic, osteopathic and homeopathic physicians. There are articles on everything from the financial aspects of practice to sex, from applied kinesiology to chemotherapy, and from dance therapy to the use of light and colors. Also included are two sections called "JEMS" which is a potpourri of different therapeutic and diagnostic concepts and ideas.

(Continued on page 29)

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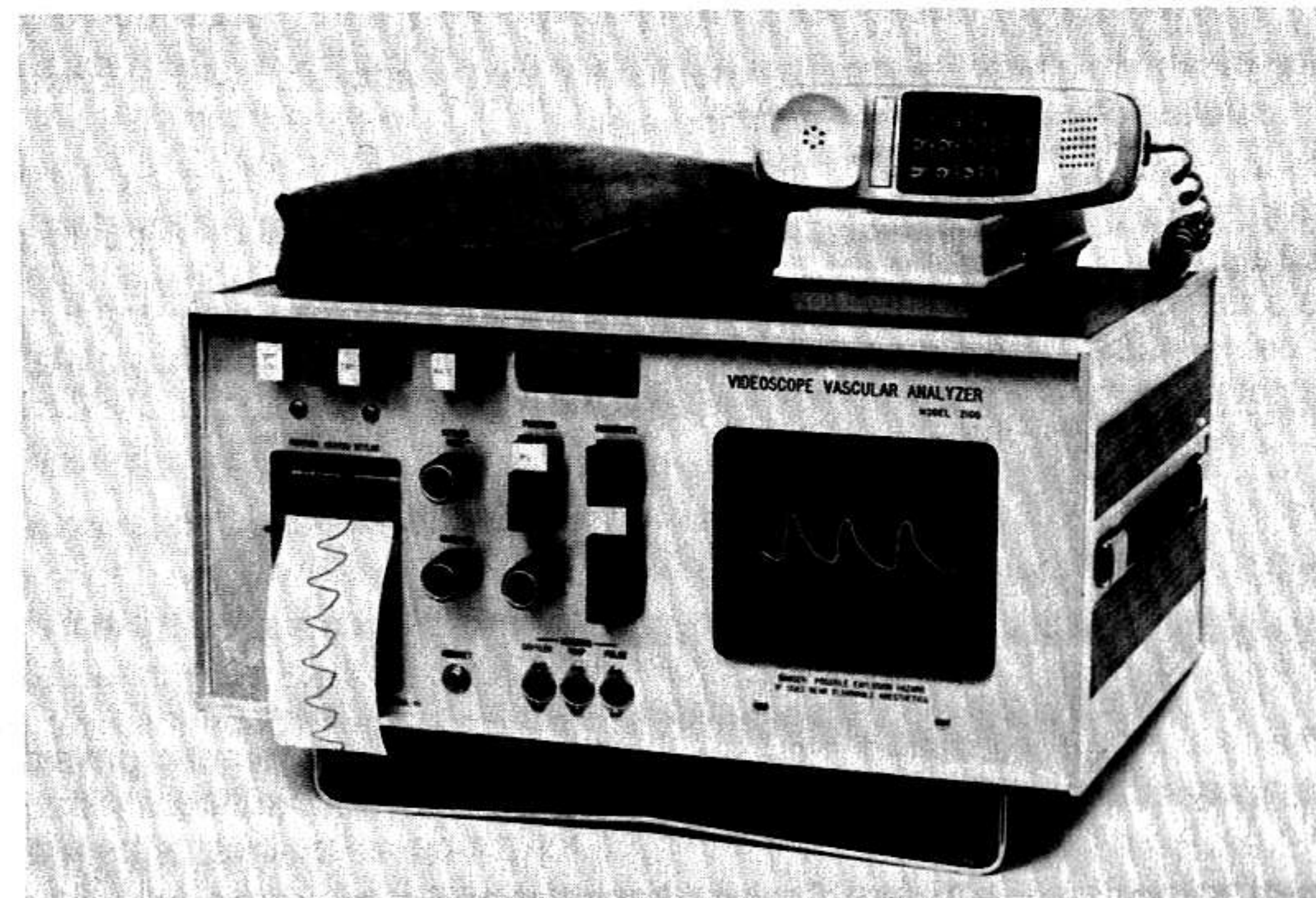
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THE ANGLO EUROPEAN COLLEGE OF CHIROPRACTIC

Eugene J. Kraemer, M.T., D.C.

Having moved to a new country (for me) for the next year or so, I wish to comment on their practice of Laboratory Medicine.

While in England, I observed that many of the Internes in the clinic are very interested in the field of laboratory medicine. Not only do they suggest the test to be used but also enjoy discussing the result with the laboratory technologist and myself. The tests are performed by our laboratory technologist, but the differential of the CBC is being studied and discussed by our internes. During my short stay at AECC I was very pleased to see their interest. I am returning to AECC on April 4, 1980 to take over as Chief of Staff of the Clinic.

I have especially observed the keen interest of the Internes in:

1. General Diagnosis including EKG
2. Complete physicals
3. Various technics

Another thing that interested me was that the outside chiropractic physicians come in every other week to teach in the forenoon and spend four hours with me in the clinic, in the afternoon, so that the internes may receive the best of training.

I expect to continue with the 'Clinical Roundtable' for the Chiropractic Family Physician with the aid and assistance of my assistant clinic director, Dr. Hutchins as well as doctors in the field from all over Europe.

If any of our readers wish to visit us in England, please write to me at the AECC at Icavendish Road, Bournemouth BH1 1RA, England. I am still available for answering questions in Laboratory medicine. ☐

(Continued from page 5)

if more within the political structure of the profession had the direction and motivation of this remarkable individual.

Ever mindful of the importance of continuing education Dr. Preiss is an orthopedist and until recently was the director of post graduate education at the LACC. Presently she is in charge of Research and Publications for the ACA Council on Diagnosis and Internal Disorders.

Dr. Preiss' consummate interest in the welfare of her country has led her into the active support of politicians whom she feels espouse viable and important deals that are in the best national interest. Because of her dedicated support Dr. Preiss was recently appointed the chairman of Chiropractors for Reagan.

Cynthia Preiss is a physician and a leader. She is a woman of great moral power and strength of purpose. She is also a gentle lady who graces all who have the privilege of knowing her. Over the years she has been greatly honored by her profession but I'm certain that she would be the first to agree that it was she who feels the honor of being allowed to serve. May the chiropractic profession be worthy of that service. ☐

(Continued from page 20)

As if all this were not enough the magazine is printed on the finest paper and the art work is superior to any I have ever seen. The photography in particular with its incredible color separation and resolution is something that must be seen.

"The Journal of Energy Medicine" is not just another magazine. It is a quality endeavor that is worthy of the concepts it espouses. It comes out four times a year and is quite expensive at \$100.00 but worth it. If interested the address is 1175 Northeast 125 Street, North Miami, Florida 33161.

Most good things cost money — so does this but you'll get your money's worth with the first issue. It's a project that has too long been hungry — I think we should feed it and keep it around. ☐

(Continued from page 22)

questioning of the mother. I used the Ohm meter to get a brain fluid scan. What we found right away was that all readings were well above normal patterns, indicating much more than normal amounts of fluid was present in all areas, but not as much as would be found in hydrocephalus. While I was working on this scan the rest of the story about the PCP was elicited from the mother.

Treatment: I first adjusted the cervical vertebrae to relieve any stress or disturbance to the carotid sinus. I then treated on the Bennett cranial areas: Anterior fontanel, frontal emotional areas, temporal tips and Mid-Sylvian areas. After this I treated the carotid sinus, parotid gland and the pituitary, all of these on both sides, with a stretch reflex contact on the trapezius muscle. After this I rechecked with the Ohm meter, and knowing then about the PCP I was not surprised that there was no improvement in the readings. I then repeated the entire treatment to all the reflex areas and rechecked with the Ohm meter. There still was no change in the readings which showed a superabundance of cranial fluid, by the high readings. This was on Friday and I released the patient to return home, but had the mother promise to return him to the office early Monday morning, before the pediatrician had an opportunity to see him. She brought him as requested and I immediately checked him on the Ohm meter. I was very pleased to find all areas completely normal, there had been no more fever or seizures and his behavior had been entirely normal.

This was very encouraging but these hallucogenic toxins are very unpredictable. I had had LSD cases previously so we are prepared to wait and watch for a period. If the symptoms return the mother has been instructed to get the boy in to me at once. There seems to be some reason to hope that since reduction of cranial fluids has had a favorable reaction, this may be the quickest way to control the symptoms of fever, convulsions and unusual behavior if they recur. This experience is included in the Chiropractic Family Physician for what it may be worth for any doctors who may have occasion to have any of these PCP cases in your practice. If there is need for any follow-up therapy on this case it will be reported in a later issue of this Journal.

Note: The instructions on treatment listed above were specifically for doctors who have the Bennett books and charts. We would appreciate hearing from any doctors who have occasion to care for PCP cases. ☐

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